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the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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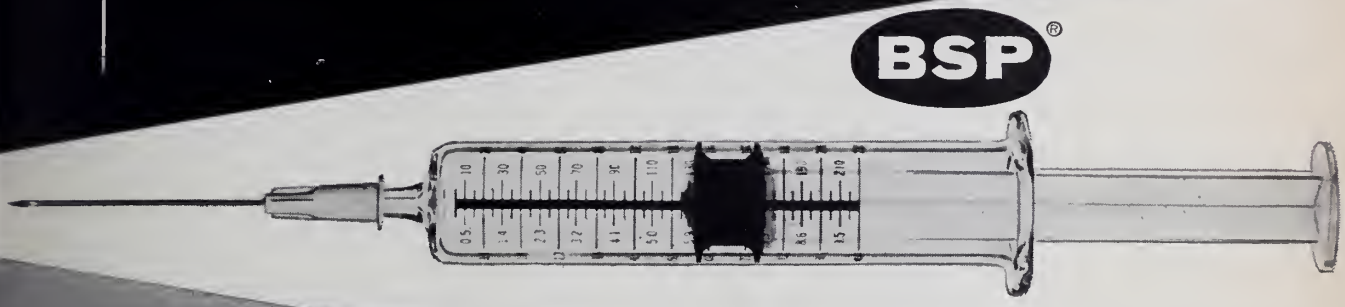
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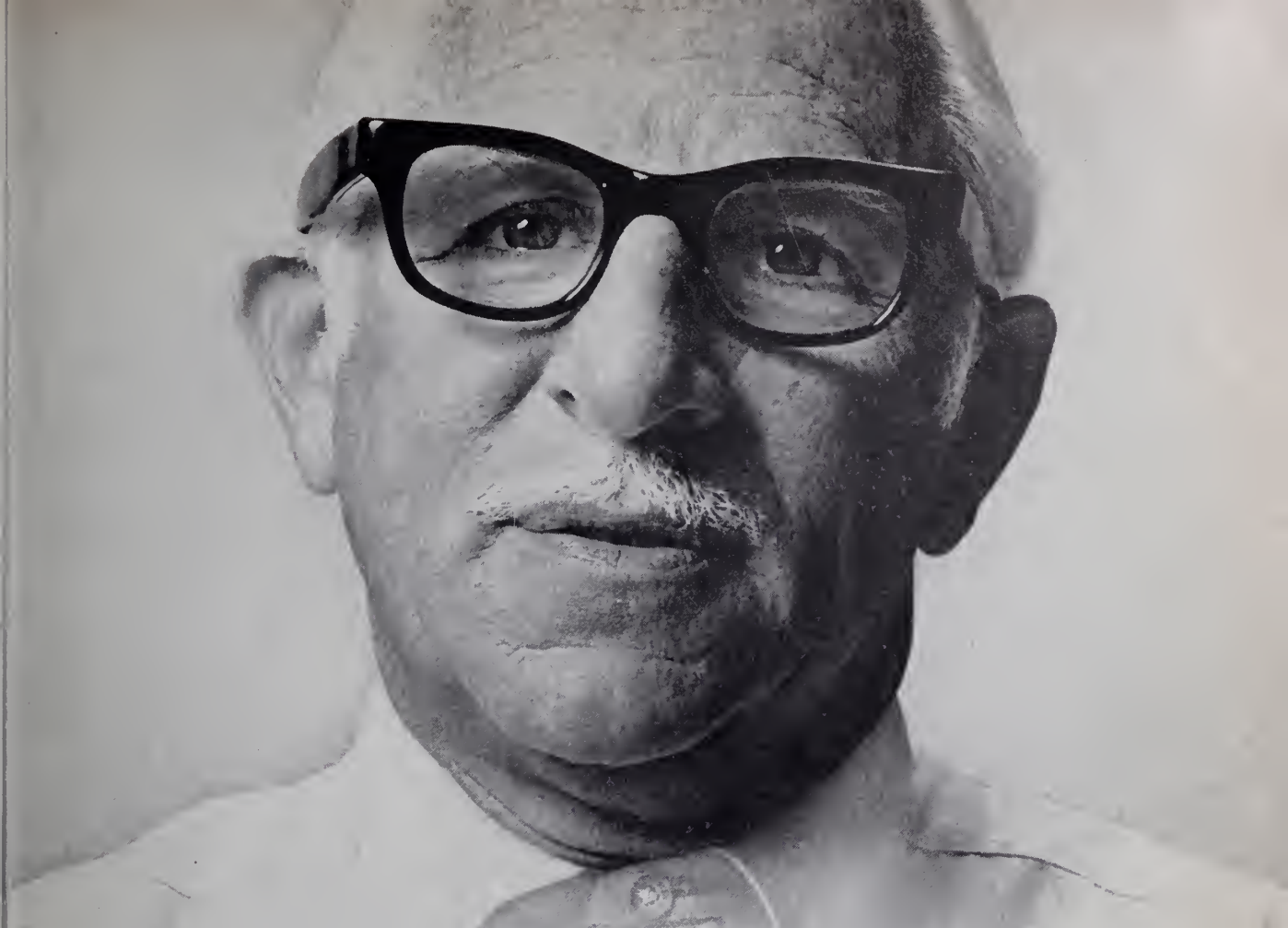
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derma-

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s, Stevens-Johnson syndrome, ell's syndrome (toxic necrotizing dermolysis),or a generalized rgic reaction similar to serum kness may occur and require rmanent withdrawal of medica- n. Agranulocytosis can occur ddenly in spite of regular, repeated rmal white counts. Stomatitis d, rarely, salivary gland enlarge- nt may require cessation of treat- nt. Such patients should not eive subsequent courses of the ug. Vomiting, vertigo and languor y occur. Leukemia and leukemoid ictions have been reported. While t definitely attributable to the ug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

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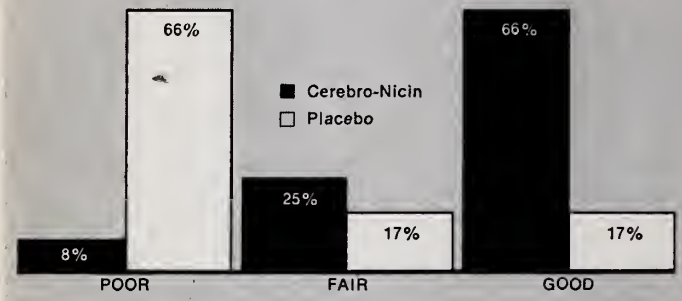


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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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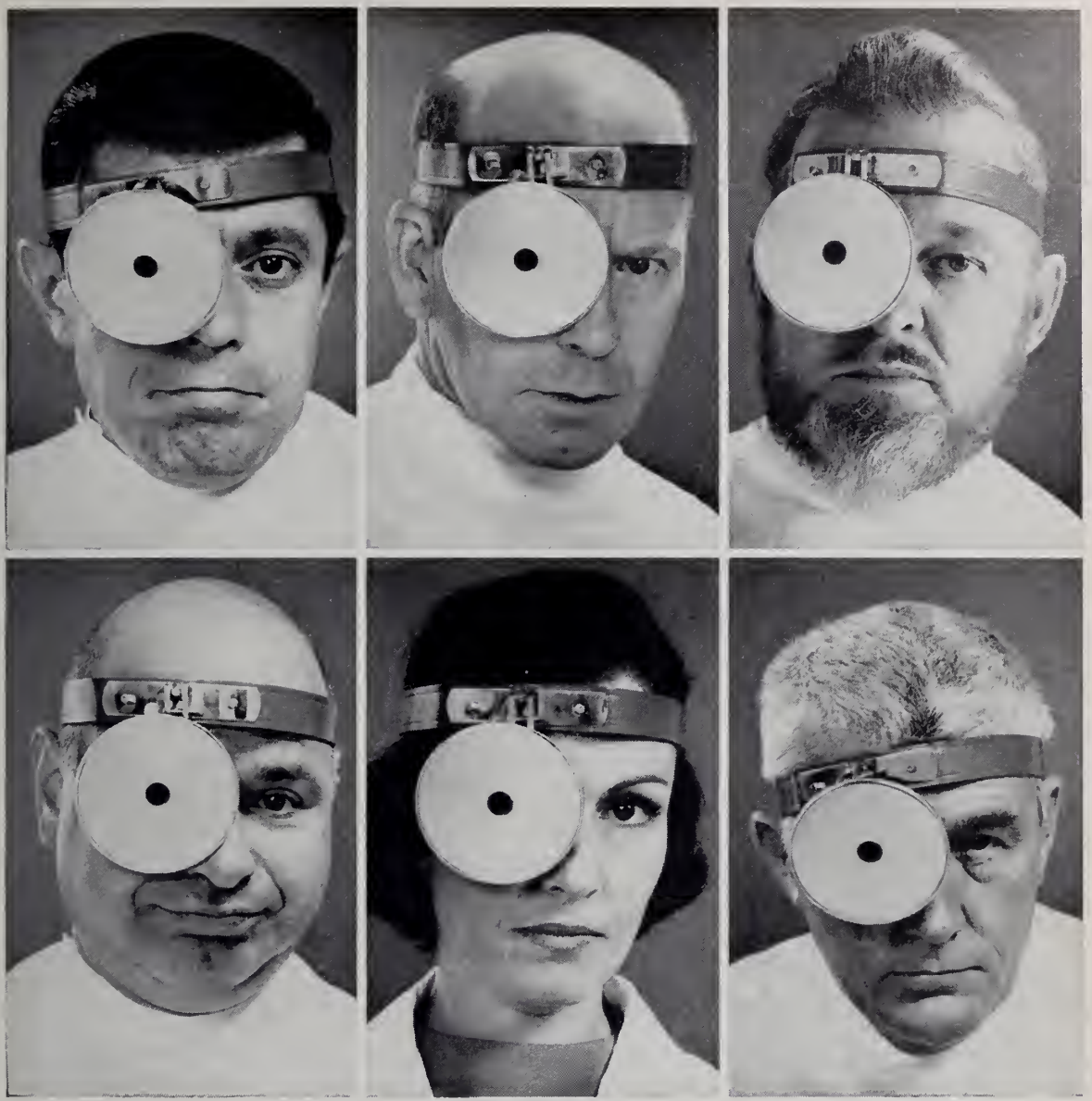
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*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

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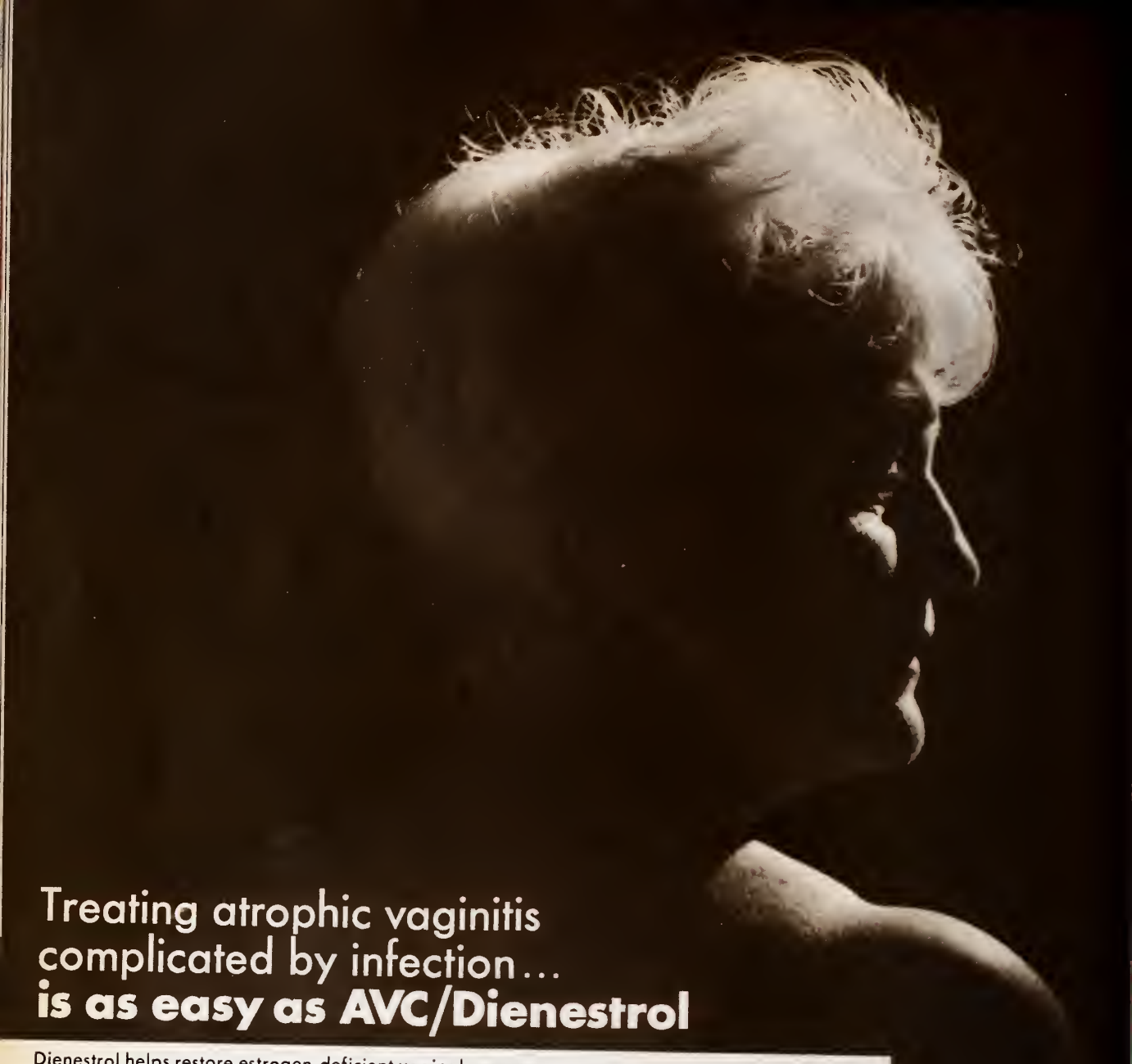
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References: (1) Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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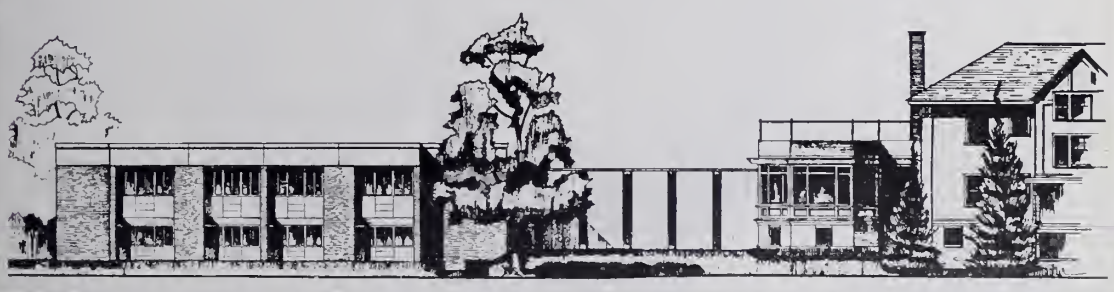
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EDITORIALS

The Elegant Prescription

Our professional sires were much concerned about the taste and smell of the medication they prescribed. This made for "elegance" in the prescription. Nineteenth century medical students were drilled in the concoction of elixirs, syrups, and fluid extracts that had pleasant (or potent) smells and tastes.

With the increasing popularity of solid medications, and the decline of the tailor-made prescription, there is less emphasis on the flavor and odor of medication. And, in a way, this is too bad. Everyone prefers a pleasant tasting, pleasant smelling (and for that matter pleasant looking) medication. An ill person is, as a rule, exquisitely sensitive to these things.

There is, furthermore, something special about the taste-smell sense. We bracket them here, for as Brillat Savarin (who ought to know) said, "Smell and taste form but one sensation, with the mouth as the kitchen and the nose as the chimney." Sight and sound are physical sensations. Solid waves reach the retina or ear drum. The smell-taste sense is chemical. It is wafted to us through the air, and no one has yet developed an objective, numerically calibrated gustatometer or olfactometer.

They are — or it is — a primitive sensation, dependent for its evocative powers on factors far more subtle than those which work with sound or sight. The latter two senses now convey ideas with words, spoken or printed. But smell and taste must work without words, with moods, memories, sentiments, and emotions. Odors are distinctive and inimitable. If sight and sound are the weapons of reason, smell and taste are the instruments of emotion.

In sickness we seek to help the bodies of patients. We also want to elevate their moods, to solace their emotions, to ease their minds, and even attend to their souls. And in these areas, smell and taste are more potent than other sensations.

The chemists in America's wonderful pharmaceutical industry have been alive to this, and in distributing liquid medications, they *do* strive for elegance in taste and smell. But it is not good that we doctors have abdicated this entirely to the manufacturer. It would hurt none of us to know how to disguise a bitter flavor with a palatable one, how to brew pleasant-smelling medicaments. It is always good taste to recognize good taste.

Coffee Break

Theobroma — literally "brew for the gods" — was what they called the cocoa beverages. The cheering and comfort here were matched by the pleasures of the Kola nut or, in the modern world, the refreshment of cola drinks. In South America, the drink was maté, in England it was tea, in the United States it was coffee.

Maté, kola, theobromine, coffee, tea, cola, and cocoa — through them all runs the thread: caffeine. That is what they have in common — that amazing methylated xanthine, also known as theine.

Here in the words of William Cowper are "the cups that cheer but do not inebriate." Tea and coffee, maté and kola have given comfort and solace to half the world. "Tea," said Colley Cibber, "thou safe, thou sober, sage and venerable liquid."

Coffee houses and tea houses have been philosophers' corners for centuries. Out of them have come intrigue, gossip, insurance, and the distribution of the news of the day. In the U.S.A. one billion pounds (not a million nor ten million, not a hundred million, but a well-rounded unimaginable billion pounds) of coffee are consumed annually. Caffeine stimulates the cortex, so that the office coffee break leads to more production per day, not less. Indeed, England started on its con-

quest of a world-wide empire only after it became a tea drinking nation.

It is not only a cheering stimulant but a safe one. Not a single human fatality has ever been reported from coffee. It makes no one drunk, robs no one of his dignity, lulls no one into Nirvana. It stimulates the myocardium, increases coronary blood flow, dilates peripheral vessels, keeps the kidneys busy, augments gastric secretion, increases the metabolic rate and serves as an antidote to poisoning by depressants.

It is the great American institution that knows no class lines. Truck drivers and debutantes, professors and stenographers, the unemployed in a bread line, the opulent in a banquet hall turn to coffee. It is a friend who never betrays, as does alcohol. It is a pleasant addiction that does not enchain as do the opiates. It is a social lubricant, a versatile medicine, an aid to clear thinking.

Here's to the coffee hour! Indeed, in some progressive offices the coffee periods are now being punctuated by work breaks. To one who is dedicated to work, a midmorning coffee or a midafternoon tea is a means of facilitating production. To one who is bored by his work, the coffee break is the best time of the day. *Theos broma,* indeed, food for the gods!

Alcoholocaust

Statistics, argue some skeptics, can be used to substantiate anything. However, according to Sterling T. Tooker, president of The Travelers Insurance Companies, statistics cannot prove how many accidents have been prevented through safety education.

Writing in the 35th edition of his company's annual booklet of highway accident data, Mr. Tooker said, "Our rationale back in 1931 was that if reasonable people know the truth about a problem, the truth will help them solve the problem. In 1969, 65 million booklets later, it is still our rationale.

"Ironically enough, this conviction cannot be based on hard statistics," he said. "Yet we know that hundreds of thousands of accidents *have* been prevented by drivers and pedestrians who have learned to drive and walk with safety. And the ever-mounting number of miles traveled on many poorly engineered roads clogged by more and more cars and trucks and buses give us real reason to believe that these ghastly casualty totals could be much higher," he added.

"Alcoholocaust" is the title of the 1969 edition of The Travelers booklet. And for the first time it takes a close look at the mixture of alcohol and gasoline. But the booklet does not contain statistics to support the title. Here's why:

The numbers and the classifications are distilled — no pun intended — from monthly reports furnished by state motor vehicle departments (a voluntary service gratefully acknowledged by The Travelers). Energetic and thorough research has nailed down drunk driving as a major accident cause, but absolute precision is still out of reach. A dead driver can't be asked to heel-and-toe or take a breath or blood test. The injured driver frequently needs swift emergency treatment. Technical examination for alcohol in his blood stream must come later when the aberrant ingredient has been diluted or has disappeared altogether.

The evidence is nevertheless overwhelming. Indeed, the U.S. Department of Transportation has issued a report to Congress which even die-hard statisticians agree is a definitive indictment of drink-then-drive offenders. This landmark study concludes that "the use of alcohol by drivers and pedestrians leads to some 25,000 deaths and a total of at least 800,000 crashes in the United States each year." Well, the point of all this is sharp to all last-ditch apologists for irresponsible social drinkers or social drinkers-and-drivers themselves.

And we are doctors, not apologists. Get the message?

ORIGINAL ARTICLES

Students on college campuses "tell it like it is" on the new morality, and have something to say about the hypocrisy of "the establishment" with its preachings.

Behavioral Patterns In Sex And Drug Use On The College Campus

Sylvia Herz, Ph.D./South Orange

There is much public concern and confusion about drugs, particularly on the college campus, with little differentiation between drug experimentation and drug addiction. The tendency is to lump the entire problem of drug abuse into the umbrella term of "addiction." Likewise, the "new sexual morality" provides little insight or tolerance for the adult community to find acceptable, thus widening the generation gap. This researcher has gone to the source, itself, and questioned the students directly. For this purpose, a detailed questionnaire* was administered by the researcher under controlled conditions. Among other aims, we have tried to determine how much information students have about drug abuse and its effects. Our findings make no attempt to speak for the general college population, but they may shed some insight on the current thinking, attitudes, and sex-drug behavior germane to the segment of the population tested.

Method

After three years of research by the investigator, a six-month study was made of a random sample of 150 undergraduate college students of both sexes, concluded in December 1967, from three local Eastern universities. This concerned their sex lives in addition to their behavior and attitudes toward drugs on campus.

The dean of the selected school was personally visited, and apprised of the need for the study and method to be used. Cooperation was gained in each instance, with the proviso[34] initiated by the researcher, that "no one university or institution of higher learning will be identified at any time." The students were not to sign the form or identify themselves in any way.

Two professors in the Liberal Arts College were selected and agreed to work with the researcher. A criterion for teacher selection was that each taught a subject that was open to students from any of the four years—freshman, sophomore, junior, and senior. Another criterion for teacher selections was that at least two of their classes met on the same day of the week to facilitate test-taking in one group under similar conditions. To meet these criteria, the two teachers who were selected fell into language and social studies departments. Each teacher worked with two of his classes in his subject area so twelve classes were involved at the three universities.

The classes were apprised of the intent and need for the study and the seriousness of the research. There was an appeal to the intellect for purposes of communication and assurance of complete anonymity of persons and universities involved. It was requested of teachers

* For a copy of the questionnaire, write to Dr. Sylvia Herz, 220 Fillou Road, South Orange, New Jersey 07079.

[34] This same proviso is stated clearly on the first page of the questionnaire in the section: *Statement of Need for the Study.*

and students that no more open discussion follow reading of the announcement; and there had been no prior announcement of the study either. The teacher selected every third person on the name roll in each class, who was asked to participate in the study. This comprised the random sampling of the population in twelve classes. No student at any time refused to take the test outright or considered it to be an intrusion of privacy. Of the total number of those randomly selected at all three universities, only seven students begged off due to prior commitments, and only three assigned students failed to show up at all.

At the appointed time and place, students were seated in chairs and the following was read:

"This questionnaire is part of a research study to learn more of the sexual activity and drug experimentation on college campuses today. Please do not sign this questionnaire but complete honesty, to the best of your ability, is necessary to get at the facts so as to evaluate our social behavioral patterns for better communication in the interest of social progress. Please answer from your own personal experience or as a viewer or from your own knowledge. The final results will be tabulated as stemming from local Eastern universities and no one university will be identified at any time. Thank you for your full cooperation."

The students silently took the test in quiet exam-like fashion, with no talking or reference to one another, while the researcher acted as proctor. Some 45 minutes were needed to complete the written test.

After all questionnaires had been collected, I asked the undergraduates whether they would like to talk about some of the material in informal conversation. This suggestion was adopted with enthusiasm and there followed a verbal outpouring of passionate charges and protests against "the establishment" and its values accompanied by an equally stirring defense of "the new morality." As it turned out these informal sessions generally verbalized more vehemently the responses submitted in writing. The same turn of events followed almost identically on all three college campuses, lasting from one and one-half to two and one-half hours longer than the written part. There appeared to be a tremendous need and desire for youth to communicate its values to the adult community.

Each student was asked to answer (a) from his or her personal experience or (b) from his or her own knowledge. Pilot studies had been made to test the reliability and validity of this instrument. This indicated an excellent order of reliability (0.68) well beyond the .01 level of significance. Further evaluations indicated a high degree of validity.

Sex Patterns

In regard to the individual's own sexual life, 42 per cent of the student sample responded that the sexual act was "often;" 19 per cent "very often;" 31 per cent "a few times;" and 8 per cent "never."

Sex was described by students, especially the males, as: "as easy to get as tying your shoelace," "nothing to it," "free and easy," "girls are often the aggressor," "just a matter of fact," "no different from eating," "why not?," "it's not so hot," "nearly everybody accepts it as cold fact," "unnatural to wait," "just another necessity of life," and "merely a body function." There was a matter-of-fact cold acceptance and description of sex as "a normal procedure" with an absence of adventure, excitement, or thrill that may have characterized it a generation ago when there was less prevalence or freedom and when it was still considered to be forbidden.

Female students, while freely acknowledging their sexual activity, came across weak and decidedly more negative in their "enjoyment," "deriving pleasure," or feeling that they were "better appreciated or liked more" as a result of these activities. Few students of either sex viewed it as a symbol of a meaningful relationship and few felt that sex should be limited only to those who were engaged or "going steady" for a long time.

A variety of student response, written and oral, indicated to the researcher that the new sexual morality and freedom on campus have been "too fast" and "too much" for some students who are neither emotionally nor phy-

sically fully ready to participate. They frequently experienced sexual inadequacies, fears, frigidity, loss of meaning or excitement, confusion, and disappointment in their relationships. Some students, on the other hand, were dulled by an activity which they characterized as "too easy" or sated by adventures which they quantified as "too much." And even among those who said that they enjoyed it all, there was much expression of casualness.

Drugs

Many of the students seem to experience a keener sense of adventure in taking drugs. Their pharmacopeia included marijuana (pot or grass), amphetamine (bennies) and acid (LSD-lysergic acid diethylamide). Both users and viewers characterized the drug experience as the "in-thing," "adventurous," "great," "taken for kicks and thrills," "excitement you can turn on when you wish," "a real change of pace," "liberation," "the only thing that gives me a lift," "sometimes weird and frightening," "one way to find meaning," "I want to know about myself," "a great escape," "it's satisfying," "relieves the dullness," "how else can we have fun?", and "what does the establishment know about morals?"

From the sample tested, 26 per cent reported drug experimentation at some time. Practically none predicted or foresaw any danger in intensive use or dependency or addiction to drugs as a life-style. Nearly all of those tested approved the use of marijuana either for themselves or for others and viewed pot as quite "safe."

About one quarter of those tested used both drugs at different times. It was estimated by users and viewers alike that 50 per cent of the student body used "pot" and that 70 per cent utilized amphetamines. Of the students tested, 8 per cent had experimented with LSD at one time or another.

More than half of the student sample (drug users and non-users) viewed LSD as producing harmful effects and possible permanent physiologic damage; a third were not sure, and the rest had no opinion. Forty per cent of the students tested felt that long-term dosage of amphetamines could induce organic changes in the nervous system. For the most part, of those tested, the college student appears to be well informed on the properties of the various drugs and their effects upon abuse.

In general, the study indicated that pot was used mainly in groups for "release from tensions," particularly after exams and in free time; LSD on week-ends, with some believing in greater insights but most acknowledging "great kicks" in addition to tales of "shattering experiences" or panic reactions; amphetamines were used for "more energy," to stay up late while studying for exams due to their "pep-up" quality and for more "pep" on dates. In all cases, where a student had experimented with drugs he said that he also had had sexual experiences.

The test plus the succeeding oral sessions made it clear that excitement, curiosity, forbidden adventure, our society's abounding permissiveness, in addition to boredom, pressures, emphasis on the "here-and-now," and disgust with the adult world and its values have led to experimentation with drugs in an already pill-drug-oriented adult society.

This investigation indicates, for the sample population, that the campus drugs — marijuana, LSD, and amphetamines — appear to have outglamorized and out-challenged sex on today's college campus, since sex is easily attainable, available, taken for granted, and appears to have lost its yesteryear spirit of adventure and conquest. The need to get away from tensions and "escape" through drugs is apparently considered by a segment of the college student population to take first priority since pot possesses a sex-inhibiting property as the individual's capacity to function is lessened.[35]

Additional Findings

Throughout the study on all topics, the stu-

[35] Case reports indicate the contradiction between "fact and fantasy" in regard to sexual prowess under the influence of hallucinogens.

dents' view of the importance of the present far outweighed ominous thoughts of the future and possible dire consequences of acts taken now. A significant number alluded to a hopeless world, deplored the Vietnam War, and feared a nuclear holocaust.

Lack of consistency or credibility on the part of the older generation came through clearly in the student philosophical caution of "don't trust anyone over 35." The students were mirroring the defects of what they described as "an adult, archaic, sick, corrupt, and hypocritical society" and to their way of thinking they were being more admittedly honest, free, and natural in their behavior than "the establishment" was in theirs.

Recommendations For Further Research

1. Similar studies on other campuses with larger samples under similarly controlled conditions are essential.

2. Studies are needed to determine differences between those students or individuals who experiment with drugs and discard them after one or more times as contrasted with those who continue on drugs and become addicted to them.

3. Studies that seek to evaluate and equate familial interaction and parental characteristics of ghetto addicts as compared with middle-class addicts may shed insight on similarities in both groups.

4. Studies should aim at evaluating the causal factors of drug abuse rather than merely studying drug abuse and/or addiction as a symptom of our time.

5. Experimental studies are needed over several years with pilot projects of controlled "no-pressure" creative classes as opposed to present emphasis on "pressured-grading" type classes as guides to the educative process.

6. Experimental studies are needed over several years with pilot projects of controlled tutored-parents in generation-gap-bridging as compared with contemporary untutored-over-protective and over-permissive parents. This may start a trend in consistent parental education.

7. Studies are needed to evaluate the college drop-out and, with assistance of the college administration and involved families, determine the relationship — if any — to drug abuse or drug addiction as a life-style.

Conclusion

There is poor communication between the generations. Youth has an almost overwhelming desire to be heard — and to be understood. The enthusiasm with which the students participated in this study is a reflection of that need. If our sample is a fair one, it would appear that youth is casting aspersions on contemporary society. We obviously need a rethinking of society's values. There is not only the much advertised gap between the generations, there is another gap that we don't talk about so much — the gap between our preachings and our own behavior.

A listing of 35 citations will be found in Dr. Herz's reprints.

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When medical therapy has been unsuccessful in rheumatoid hand disorders, surgical intervention should be seriously and thoughtfully considered.

Surgical Treatment Of The Rheumatoid Hand*

William J. Bruton, M.D./Summit

Bayles[1] has estimated that one in sixteen women over the age of 55 (or 6 per cent of the population) has classical or definite signs of rheumatoid arthritis. In many of these, there is significant involvement of the wrist and/or hand. It is important that the indications and procedures available for the surgical treatment of the rheumatoid hand be well understood. Major considerations are to deal with fears of pain and disability. In the past, the emphasis has been on the relief of pain and the restoration of function. Fortunately, however, in recent years the emphasis has shifted to *prevention* of pain and *preservation* of function. Appearance is rarely the prime indication for surgery in the rheumatoid hand, but, it must be remembered that a functioning hand is more acceptable cosmetically than one that is disabled.[6]

The prime offending agent in every deformity in the rheumatoid hand is the synovium. Rheumatoid arthritis is a disease of the synovium. Synovitis leads directly to destruction of articular cartilage, joint capsules and ligaments, and tendon rupture. If the synovial proliferation cannot be controlled by adequate medical therapy within a reasonable period of time (i.e., four months of adequate salicylate therapy and/or gold salts), then early synovectomy prior to further soft issue and joint destruction will afford the best over-all results. A lining histologically similar to synovium will regenerate following synovectomy, but massive synovitis is uncommon.[6]

The Dorsal Surface of the Wrist

Early indications for surgery of the dorsal aspect of the wrist include synovitis of the distal radio-ulnar joint with pain over the ulnar styloid and synovitis of the extensor tendons of the wrist. The synovitis frequently originates in the intercarpal joints or the radiocarpal joint and may not be clinically evident because of the tight ligamentous structures present dorsally. Considerable involvement of the articular cartilage with extensive joint destruction can occur prior to penetration of the dorsal capsule by the synovitis. The synovitis then leads to volar subluxation and dislocation of the wrist, involvement of extensor tendons and eventual tendon rupture. Treatment in the early stages consists of complete synovectomy of the radiocarpal, intercarpal, and radio-ulnar joints, excision of the distal ulna (Darrach Procedure),[2] and synovectomy of the extensor tendons. Later stages require radiocarpal stabilization through the denuding of what articular cartilage remains on the proximal carpal row and distal radial articular surfaces and temporary fixation with a Steinman pin. This produces a fibrous anklyosis which results in a painless stable wrist joint but also permits a limited range of wrist motion. Wrist arthrodesis is rarely performed except in those patients in whom the disease is so far advanced that there is no soft tissue remaining that can be utilized to reconstruct some type of dorsal ligamentous support.[7]

Tendon rupture at the level of the wrist occurs as a result of synovial invasion of the tendons and also as a result of the irritating effect of the underlying eroded bone. Tendon repair

* Read before the section on Rheumatism, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 19, 1969.

is performed at the time of wrist synovectomy and stabilization. This can be performed by means of a side-to-side anastomosis to the uninvolved extensor tendons or through the use of the extensor indicis proprius in the case of a ruptured extensor pollicis longus tendon.

The Volar Aspect of the Hand and Wrist

Early involvement of the flexor tendons manifests itself frequently as stenosing tenosynovitis with snapping or trigger fingers. Synovitis of the *profundus* tendon can frequently result in blocking at the bifurcation of the *superficialis* tendon. Carpal tunnel involvement results in interference with free excursion of the flexor tendons because of their matting together and also frequently produces paresthesias and pain in the median nerve distribution. Diminished sensation and thenar muscle atrophy are late signs, and at this stage of the disease, the nerve damage may be irreversible. Careful observation and examination of the volar aspect of the hand and wrist will reveal flattening of the proximal palm because of the proliferative synovitis pressing against the undersurface of the transverse carpal ligament. Also, bulging of the synovium proximal to this ligament can be demonstrated when the wrist is placed in the position of dorsiflexion. Palpation of the palm should be performed carefully to determine the presence of nodules along the flexor tendons.

Treatment again is careful synovectomy as well as release of the transverse carpal ligament and flexor tendon sheaths. Active synovitis can, and frequently does, involve the entire flexor tendon, and synovectomy may require complete exposure of the flexor tendon including the portion within the digit.

The Metacarpophalangeal Joints

The striking deformity associated with the metacarpophalangeal joints is "ulnar drift." This is, however, a late stage of the disease which again begins with synovitis within the metacarpophalangeal joints. "Ulnar drift" begins with synovial proliferation. Synovectomy prior to joint destruction leads to the best functional and cosmetic results. With persistent synovitis the result is distention and destruction of capsular and ligamentous structures, ulnar displacement of the extensor tendons, articular cartilage destruction, and ulnar and volar subluxation or dislocation of the proximal phalanges.

Treatment at this stage[5] is a combination of resection arthroplasty of the metacarpophalangeal joints together with excision of the *abductor digiti minimi* muscle and intrinsic transfer of the lateral bands from the ulnar side of one finger to the radial side of the dorsal capsule of the adjoining finger (i.e., index to long, long to ring, ring to little). This provides an active mechanism for counteracting "ulnar drift." Pinch control of the index finger is managed through advancement of the insertion of the first dorsal interosseous muscle.

Recently, the interposition of a silicone rubber metacarpophalangeal joint prosthesis, developed by Swanson,[8] has shown great promise and appears to result in better function and cosmetic appearance and requires less postoperative physiotherapy.

Deformities of the Fingers

With extensive finger joint destruction, the best salvage procedure is interphalangeal joint arthrodesis in the position of function. Boutonniere deformities are frequently difficult to treat. Release of the lateral bands to permit flexion of the distal interphalangeal joint together with repair of the central slip of the extensor tendon may result in improvement in function and appearance.

Swan neck deformities are more successfully treated by synovectomy of the proximal interphalangeal joints combined with a retinacular reconstruction (Littler[4]) in which the lateral bands are released proximally and left attached distally, passed as separate structures beneath Cleland's ligaments and sutured to the flexor tendon sheath in the region of the proximal portion of the finger with the proximal interphalangeal joint in slight flexion. This then acts as a restraining ligament preventing hy-

perextension at the proximal interphalangeal joint.

The Thumb

Deformities of the thumb frequently result in flexion at the metacarpophalangeal joint and hyperextension of the interphalangeal joint. If dislocation and joint destruction have occurred, arthrodesis is the procedure of choice. If the articular cartilage is still present, reconstruction of the extensor mechanism at the level of the metacarpophalangeal joint can be considered. A method of reinforcing the dorsal structures involves the advancement of the extensor pollicis brevis with suture of it to the base of the proximal phalanx and transfer of the insertions of the *abductor pollicis brevis* and *adductor pollicis* muscles to the dorsal aspect of the capsule of the metacarpophalangeal joint. This serves to reinforce the capsule, provide extension of the proximal phalanx as well as allow for correction of the hyperextension attitude of the interphalangeal joint.[3] The long flexor can then provide flexor power thus restoring a proper pinch mechanism.

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120 Summit Avenue

Forecast For Future Of Medicine

The *AMA News,* in its October 20, 1969 edition, tells us that a perceptive look at the future of medicine in this country has been made by one of the nation's foremost health experts, whose identity can't be revealed.

Of most immediate interest to physicians is the prediction that universal health insurance or a substitute that provides equal access to health care regardless of finances will come about within a relatively short time.

In a chat with *American Medical News,* the expert made these other predictions:

1. Socialized medicine along British lines will not prevail.

2. Private practice will predominate.

3. Hospitals will grow in importance, and become an organizing center for continued care.

4. Solo practice eventually will disappear, to be replaced by grouped or informally linked physicians.

5. Health care will become increasingly institutionalized.

6. Increased use of allied health workers with corresponding increased role of physicians as over-all *manager* of delivery of health services rather than *deliverer* will be prevalent.

7. Health-care will become much more "consumer oriented."

Of the various diagnostic modalities in the pneumoconioses, chest radiography is the most important.

The Pneumoconioses*

Joseph F. Inzinna, M.D./Jersey City

Pneumoconiosis is a generic term to describe disorders where solid foreign substances are inhaled and stored in the lung. The pneumoconioses form a group of occupational diseases which, in spite of industrial automation and protection, continue to be a major health and economic problem in industrialized states. New Jersey is a prime example where an average of $1,000,000 in compensation has been paid in each of the preceding three years. It is second only to chronic bronchitis in paid compensation from occupational diseases, and it ranks fourth in frequency after bronchitis, deafness, and dermatitis in total annually reported cases.[7] While complete and meticulous clinical and occupational studies are necessary to appraise the nature and degree of pulmonary disease and its associated disability, roentgenography of the chest is the most important single tool in establishing the existence and actual stage of these entities. Indeed, the clinical extent of this problem was not brought to light until the early nineteen hundreds, when such radiologists as Caldwell, Pancoast, and later Pendergrass studied this disease and improved technics for chest radiography.

The general practitioner and radiologist do not encounter cases of pneumoconiosis very frequently outside of the industrial sector. They do exist, however, and with the increased incidence of bronchitis, emphysema, and lung cancer in the general population, this becomes a major problem in differential diagnosis. In fact, a myriad of diseases can cause similar or identical radiologic changes.

Any of the collagen diseases, (scleroderma periarteritis nodosa, systemic lupus erythematosis, and so on), sarcoidosis, lymphangitic pulmonary metastases, Hamman-Rich syndrome, miliary tuberculosis, pulmonary adenomatosis, cystic bronchiectasis, hemosiderosis, and histiocytosis X are capable of producing lung changes that resemble the radiographic findings of the pneumoconioses.

Asbestosis and berylliosis are found in office

* Read before the Sections on Chest Diseases and Clinical Pathology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 19, 1969

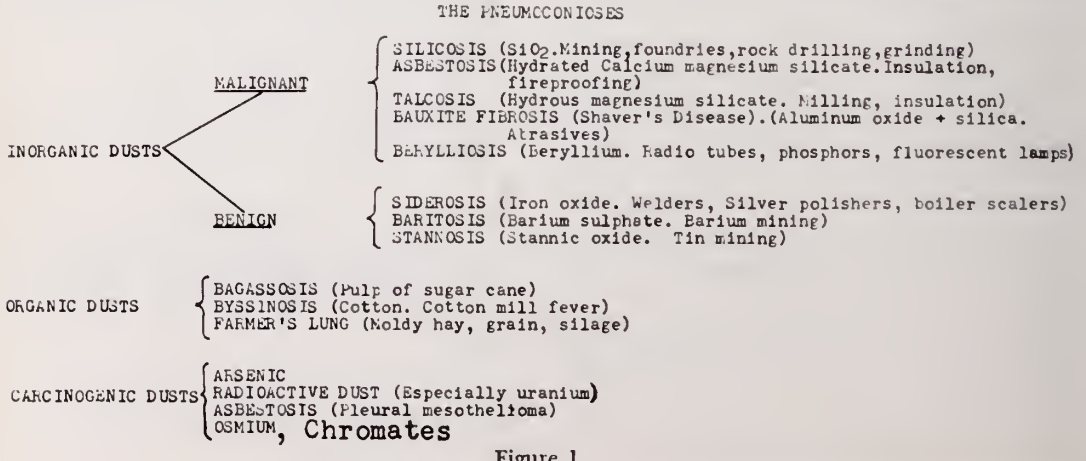


Figure 1

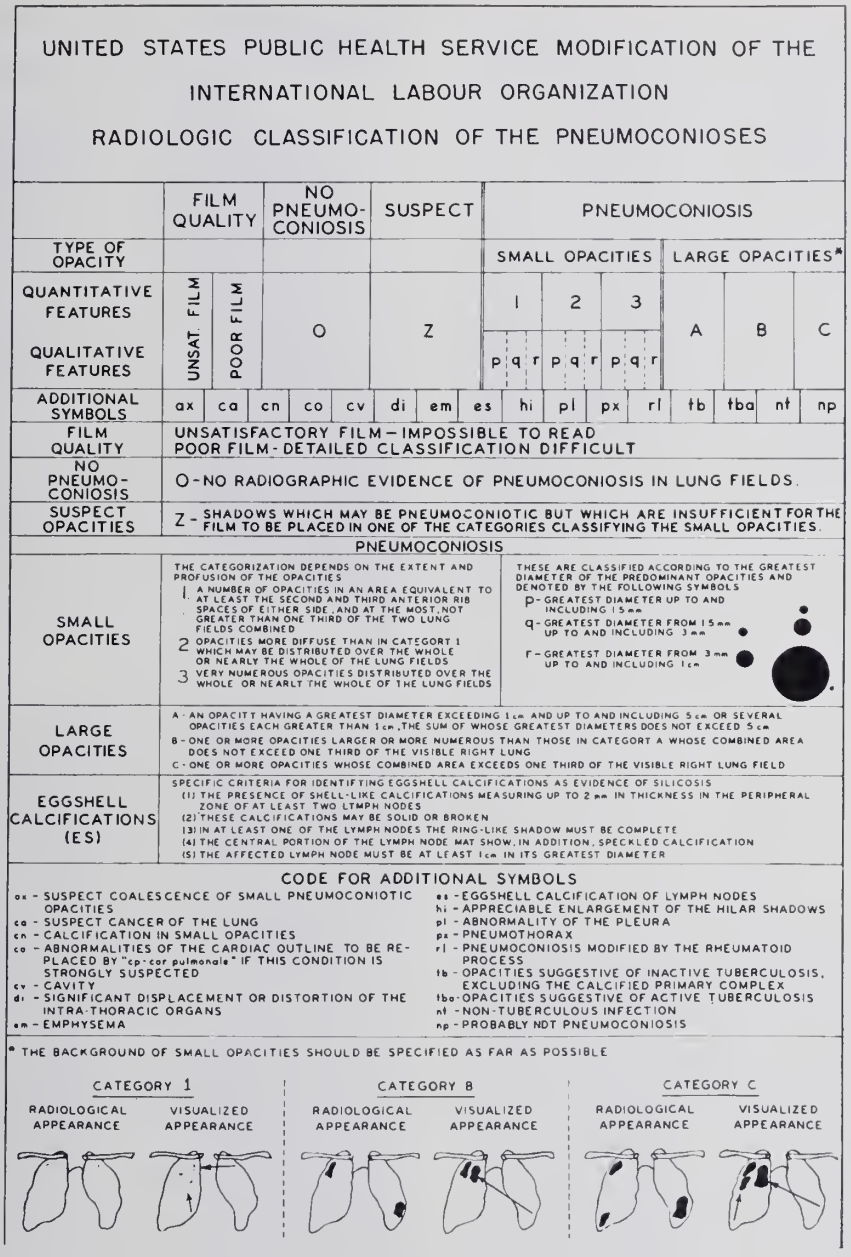


Figure 2

personnel employed in these factories and in the families who shake out the clothes of those who work these materials. Thus it is necessary to become familiar with this disease. This is especially the case in New Jersey where these industries exist.

Industry has done much in instituting protective measures since it has been found that the concentration of the dust cloud, the duration of exposure and the size and chemical nature of the particles are the major factors in producing these lesions. There is also an autoimmune mechanism which varies with each individual and which also is of major importance.

The simplest radiologic classification is to divide inhaled inorganic dusts into those that produce pulmonary fibrosis that lead to de-

creased pulmonary function (and could be termed "malignant") and those conditions which cause x-ray changes but do not cause significant fibrosis which could be termed "benign" (Figure 1).

Graphite, carbon and coal dusts (anthracosis) have been excluded since there is controversy as to whether these substances actually cause lung fibrosis independently or must be mixed with silica to produce fibrotic changes. Talc has been included because its fibrous form can cause pulmonary disease, although it actually is a form of asbestos.

The pneumoconiosis problem is a global one, and the International Labour Organization[4] in 1958 adopted a complete radiologic classification which places x-ray changes in well-defined categories. It considers only opacities caused by the inhalation of mineral dusts without specification as to the etiologic agent nor the actual clinical course. It was then modified in this country by the United States Public Health Service[1] (Figure 2). The U.S.P.H.S. classification deletes category "L" which included linear opacities that are difficult to define. A larger breakdown of category "Z" is made where pneumoconiosis is suspected and a notation for unsatisfactory films is provided. Radiologists may differ in their choice of factors but once a technic has been chosen, it must be rigorously followed by all technicians if we are to discover these lesions in their earliest stages.

Silicosis

First or Prenodular Stage (Figure 3). The earliest findings are exaggeration of the bronchovascular markings, slight prominence of the hila and minimal emphysema. This is the stage that has been deleted from the Public Health Service classification since so many lesions can cause this abnormal linear pattern of lymphatic dilatation and obstruction and perivascular lymphatic thickening and fibrosis. Previous films are often necessary for comparison in order to visualize early changes.

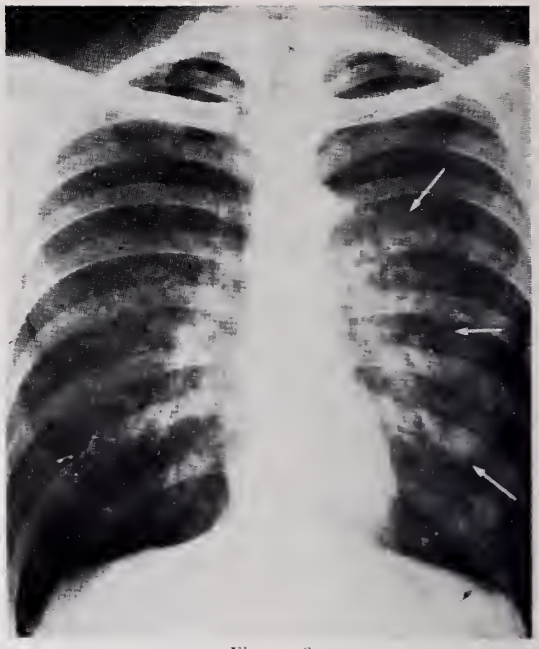


Figure 3
Prenodular or First Stage of Silicosis—Abnormal linear pattern (arrows). Hilar prominence and emphysema.

Second Stage (Figure 4). Nodules begin to appear which are homogeneous, irregular in diameter and usually demonstrate well demarcated borders. They begin in the middle third

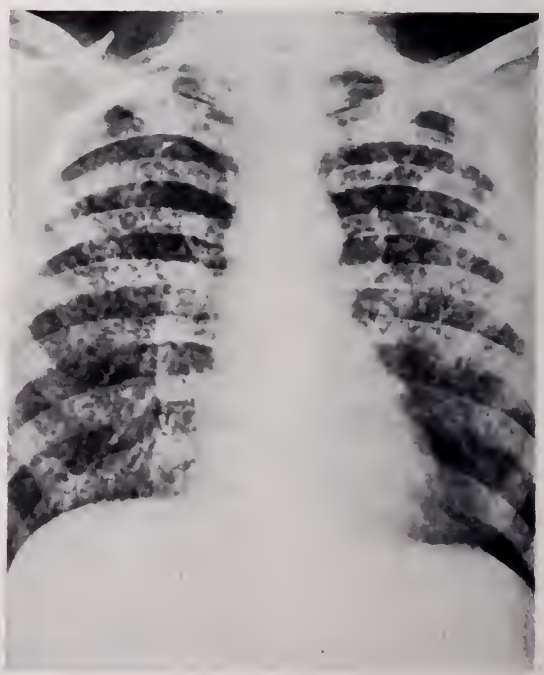


Figure 4
Nodular or Second Stage Silicosis—Irregular nodulation.

of the lungs sparing the apices and bases where basilar emphysema occurs. At times, they can be brought to light only by tomography. The hilar regions become prominent and larger, the normal bronchovascular pattern begins to disappear. The nodules become larger with their densities varying with the concentration of the silica and possible contamination with other inhaled particles, such as coal dust. An abnormal bronchovascular pattern appears due to the lymphatic obstruction previously described.

Third Stage (Figure 5 and 6). There is the characteristic coalescence of nodules or formation of massive shadows. This is "P.M.F.," progressive massive fibrosis of Kerley.[6] The nodules do not really coalesce but actually are forced together by bullous emphysema and subsegmental atelectasis. Many believe that infection is necessary to produce these masses



Figure 5

Third Stage Silicosis — Early coalescence of nodules.

which usually commence in the infraclavicular areas, but do not extend to the periphery. At this point pulmonary tuberculosis should be ruled out (Figure 7). The three major complications are infection, especially tuberculosis, *cor pulmonale,* and possibly carcinoma. Caplan's disease is an interesting entity of rheumatoid arthritis with pneumoconiosis.

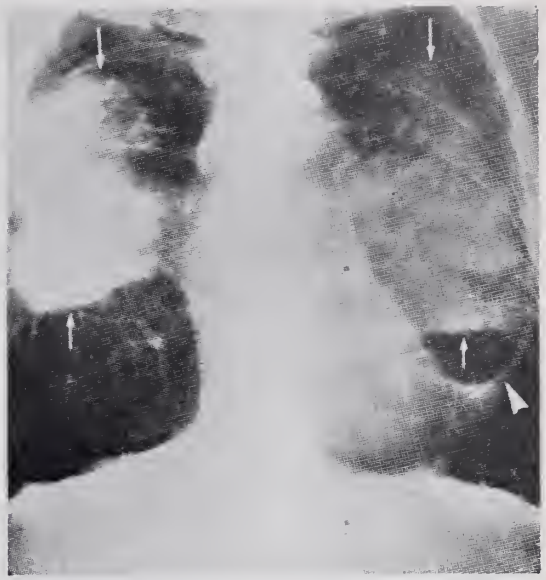


Figure 6

Late Third Stage Anthracosilicosis — "Bat wing" coalescent nodules (arrows). Large bullae (arrow head). Advanced emphysema.

Asbestosis

The clinical findings are progressive dyspnea often out of proportion to the amount of radiologic changes. Actual finger clubbing may exist as well as finding asbestos bodies in

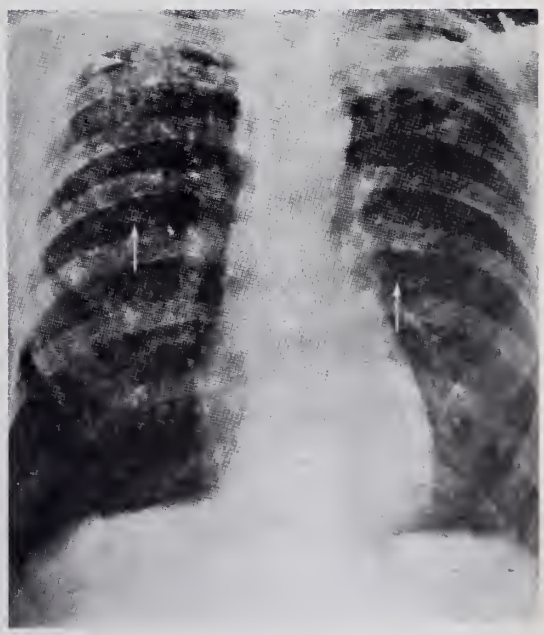


Figure 7

Silicotuberculosis — Silicotic Nodulation (arrows). Infraclavicular tuberculous infiltrate (arrowhead).

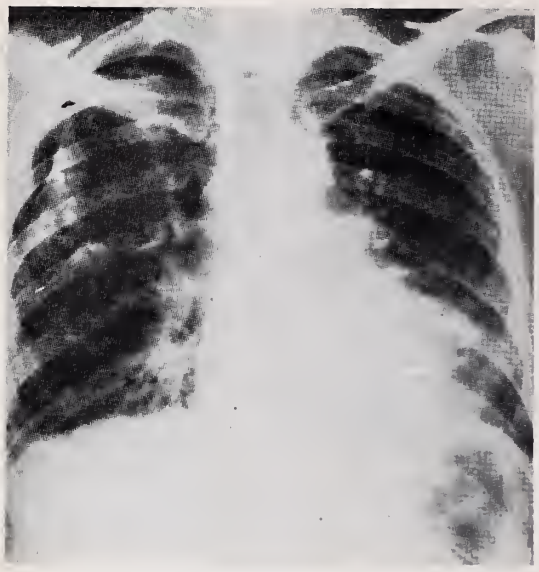


Figure 8

Asbestosis — Irregular heart border (large arrowhead) or "Porcupine Heart." Localized pneumothorax and pleural reaction (small arrowhead). Irregular nodulation, especially at bases.

the sputum with a normal chest x-ray. A nonspecific interstitial fibrosis occurs in the perihilar regions and bases which is symmetrical. Later a granular ground-glass type infiltration becomes apparent. The fibrosis extends throughout both lungs and also involves the pleura giving the cardiac borders and diaphragms a shaggy appearance sometimes called "porcupine heart." (Figure 8) Marked emphysema occurs with blebs and bullae. True nodulation and massive shadows do not occur. If large opacities are seen, carcinoma should be considered. Pleural diaphragmatic plaques occur and there is a high incidence of pleural mesothelioma (Figure 9). Peritoneal mesothelioma and carcinomata of various systems, as the gastro-intestinal tract, are noted with higher frequency.



Figure 9

Asbestosis — Pleuro-diaphragmatic calcified plaques (arrowheads).

Talcosis

This is actually a form of asbestosis (Figure 10). Roentgen findings and clinical signs of fibrous talc inhalation are similar. The chalky type of talc (that should be employed in baby powder) is innocuous.



Figure 10

Talcosis — Early linear basilar striations (arrowheads) with discrete nodularity. These are the earliest changes noted in Talcosis or Asbestosis.

Berylliosis

The acute form consists of a chemical pneumonitis that results in pulmonary edema and hemorrhage. It tends to develop in several days to two to three weeks. Radiologically, an aspecific type of central pulmonary edema is seen. If the disease does not terminate fatally within three weeks, there can be recovery or

it possibly may advance to the chronic form. The chronic form has a latent period of three to twelve months, or even several years, the lung granulomata can be confused with sar-

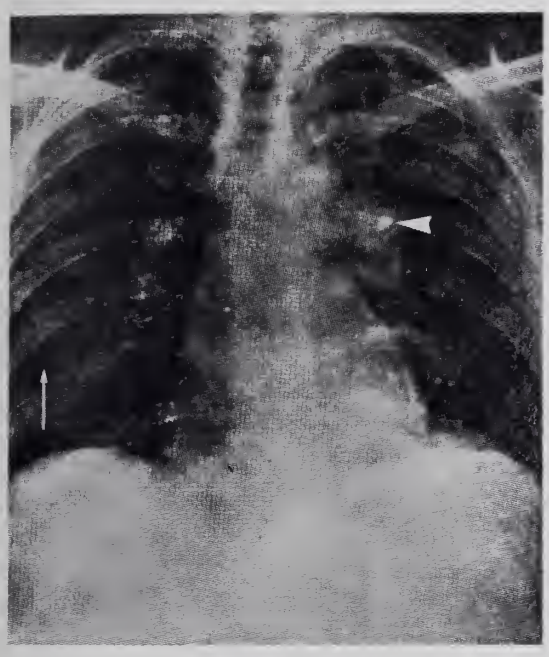


Figure 11
Berylliosis — 20-year-old male exposed to beryllium fumes. Extensive nodularity (arrow). Prominent hilar shadows (arrowhead). Chronic beryllium grandulomata.

coidosis. There is a uniform diffuse granularity. Then a reticular pattern becomes superimposed, and finally the nodules or granulomata from 1 to 5 millimeters appear with prominence of the hila. There are no node or pleural calcifications seen (Figure 11).

Benign Pneumoconiosis

The benign pneumoconioses including siderosis, stannosis, and baritosis cause no undue pulmonary fibrosis and therefore no unusual clinical symptoms (Figure 12). The radiologic picture reveals showers of the metallic nodular deposits with no undue emphysema and no appreciable fibrosis. These dusts often are combined with silica and then do cause pulmonary disease. In their pure state they are important—in that they must be differentiated from the "malignant" group.

Organic Dust Inhalation

Organic inhaled particles may cause acute pulmonary symptoms and may lead to fibrosis

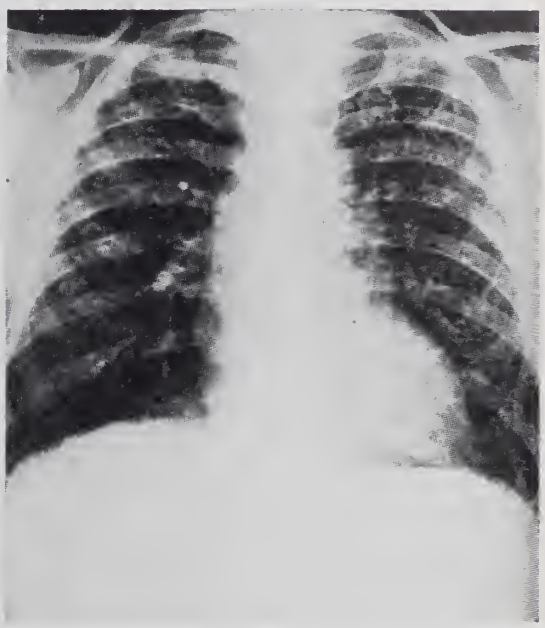


Figure 12
Siderosis — Diffuse nodulation. No real emphysema. Hilar shadows normal. No clinical symptoms.

such as bagossosis (pulp of sugar cane) byssinosis (cotton mill dust) and Farmer's lung (moldy hay, grain, or silage).

They occur with greatest frequency in the farming area of the South and Mid-West. These are believed to be caused by an antigen-antibody reaction. Some investigators suggest that Farmer's lung is actually a mycotic infection. Others consider that, while the latter disease shows spores of fungi in the dust, it is a pulmonary reaction to a non-specific irritant, probably a foreign protein, along with some degree of individual sensitivity.

There is considerable variation in the roentgenographic findings in these patients. Usually present is a fine granular nodulation occupying most of both lung fields with a tendency to spare the apices. Perihilar consolidations can also occur. These non-specific radiographic findings must be differentiated

from tuberculosis and other chronic pulmonary inflammatory diseases, therefore making it necessary to examine and culture the sputum when any question as to the diagnosis exists.

Summary

The characteristic radiologic patterns of the major inorganic pneumoconioses have been offered along with two radiologic classifications. The chest radiograph is the most important diagnostic tool in establishing the existence and actual stage of these disorders. Still, careful physical examination and investigation as to occupational exposure is fundamental since so many other pulmonary diseases can cause the same radiographic findings.

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921 Bergen Avenue

Medical Standards For Driving

A new attack has been launched on the problem of providing a more adequate method of determining the fitness of applicants for driver's licenses. The spearhead of the attack is a new guide, "Determination of Need for Medical Evaluation in Driver Licensing," just developed by the AMA Committee on Medical Aspects of Automotive Safety.

This guide, aimed at non-medical licensing authorities, suggests a screening procedure to be used on all license applicants, with only those seeming to present an unwarranted risk as drivers being required to have an examination by a physician. To do such screening effectively, lay licensing authorities will have to have medical advice and guidance. The Committee on Medical Aspects of Automotive Safety suggests that state medical association committees on automotive safety work very closely with state licensing authorities and also with county medical societies.

In addition to improving licensing procedures, the AMA Committee feels that this new guide will go a long way toward eliminating agitation for legislation which would require medical examinations for *all* drivers, as well as that which proposes compulsory reporting by physicians of conditions in their patients which might make driving unsafe. Both of these principles have been opposed by the medical profession for many reasons, principally that they are unworkable. In addition, the compulsory reporting proposal is felt to interfere with the confidentiality of medical records as well as with the traditional physician-patient relationship.

"Determination of Need for Medical Evaluation in Driver Licensing" was published in the March 4, 1969 issue of JAMA. You may obtain a reprint from the Committee on Automotive Safety, AMA, 535 North Dearborn Street, Chicago, Illinois 60610.

Tympanoplasty must be aimed, not only at improving hearing, but also at controlling the basic disease process.

Tympanoplasty Results At One And Two Years By Types*

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Corrective surgery for the chronic ear still remains one of otolgy's most difficult and demanding tasks. The aims of tympanoplastic surgery are, first, the control of the disease process, and second, the improvement of hearing. There are times when these two aims are in conflict. Control of disease many times involves *removal* of diseased tissue which may lead to further loss of hearing. However, with all the concepts of improving hearing by repositioning, the use of wire, and various prosthesis, many of these problems are now overcome. Hearing improvement rarely, if ever, occurs unless an ear is healthy and clean. Good hearing also does not occur unless there is a normally functioning eustachian tube. This, I still find, is one of the most important problems in hearing improvement in chronic ear surgery. It is unlikely that hearing improvement will occur and continue unless the diseased process is completely removed. Our measurement of success is based on a secondary factor rather than the primary aim of chronic ear surgery. Nevertheless, it does reflect our success on the primary factor.

The Committee for the Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology was charged with the duty of preparing a classification for the operations on the middle ear and mastoid that would be both comprehensive and simple. This group consisted of authorities representing 15 institutions from all over the United States. They offered a classification of the operations done for surgery of chronic ear infections. A comprehensive evaluation of the results requiring a description of the pathologic changes was also requested. The third part of the report was for citing the results in chronic ear surgery. Here again, it was common practice to report the results only in terms of hearing improvement; yet the elimination of infection, the preservation or restoration of anatomy and function were equal in importance. The reporting was finally divided into four classifications. First, the control of pathology; second, the anatomic status; third, the functional status; fourth, post-operative complication.

In the reporting on hearing improvement or the functional status, statistics were requested to be reported where the air/bone gap had been closed to within 10 dB, 20 dB, 30 dB, where there was no change, or where the hearing was made worse. In the series to be presented here the hearing results were followed for a two year period of time; there will be 117 cases. This series represents cases done from 1964 through 1966. It also represents less than half of the procedures performed during this period. The reason for this is that many were lost to follow-up after several months and some never did return once the ear, apparently, was completely

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heated, because of the travel involved. There were also some patients on whom revisions were done. I do not include these because they do not qualify as "two year results." For instance, if a patient has an operation and has a certain result at twelve months and requires a revision at 18 months, then, there is really no two year follow-up on this particular patient for the original operation. Therefore, cases of this nature were eliminated.

Table 1 represents the results of 63 cases of Type I tympanoplasties. Primarily, the pathology involved was a perforation of the tympanic membrane. The ossicular chain was intact. In some cases, skin from the external auditory canal was used as a graft to close the perforation and in others fascia was used, utilizing a post auricular incision. One notes that there is very little change between the statistical results at one year and two years.

TABLE I

AB Gap Closed	*1 year*	*2 years*
10 dB	38 (60.3%)	38 (60.3%)
20 dB	10 (15.3%)	9 (14.2%)
30 dB	1 (1.6%)	2 (3.2%)
No Change	9 (14.2%)	9 (14.2%)
Worse	5 (7.9%)	5 (7.9%)
Total	63	

Table 2 represents 40 cases of Type II tympanoplasties. In these cases, the most frequent pathologic condition found was erosion of the lenticular process of the incus. Most of these represent a repositioning type of operative reconstruction. One sees that there is some regression between one and two years in these cases. This most likely represents further necrosis of the repositioned incus.

TABLE II

AB Gap Closed	*1 year*	*2 years*
10 dB	4 (10%)	3 (7.5%)
20 dB	8 (20%)	6 (15%)
30 dB	6 (15%)	9 (22.5%)
No Change	16 (40%)	16 (40%)
Worse	6 (15%)	6 (15%)
Total	40	

Table 3 represents five cases of Type III tympanoplasties. Here there was incus necrosis; or the incus had been completely eroded and a tympanostapidopexy type of procedure was performed. There is very little regression from one to two years in these cases.

TABLE III

AB Gap Closed	*1 year*	*2 years*
10 db	1 (20%)	1 (20%)
20 dB	2 (40%)	1 (20%)
30 dB	1 (20%)	2 (40%)
No Change	1 (20%)	1 (20%)
Worse	—	—
Total	5	

Table 4 displays nine cases of Type IV tympanoplasties. The pathologic findings were usually necrosis of most of the ossicular chain. In these cases, the arch of the stapes also had been eroded away and only the footplate remained.

TABLE IV

AB Gap Closed	*1 year*	*2 years*
10 dB	—	—
20 dB	—	—
30 dB	1 (11.1%)	1 (11.1%)
No Change	5 (55.5%)	5 (55.5%)
Worse	3 (33.3%)	3 (33.3%)
Total	9	

Conclusion

More than 100 cases have been followed for a two year period and the results (insofar as hearing improvement is concerned) have been reported. This was a group of patients followed without revision or evidence of further disease over this period of time. Since these cases were performed, other technics have been utilized in reconstructive surgery, especially in Type II cases. This primarily involves the use of wire from the malleous to the stapes instead of the repositioning procedure. One can see from these results in the reconstructive operations for hearing improvement in chronic ears that there still remains much research and improvement in technic in order to better these results.

3701 North Broad Street

Group therapy can be effective in modifying lowered self-esteem, and in providing a safe environment for unmarried mothers to ventilate their frustrations and anxieties.

Brief Group Psychotherapy With Unwed Mothers*

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The dynamic influences and characteristics of maternity and unwed motherhood have inspired a significant amount of literature. Works on the psychotherapy of unwed mothers, however, are far less numerous (Khlentzos[6]). Only a few descriptions of group psychotherapy exist (Slavson[9], Steinmetz[10], Finger[4]), although other types of group sessions with unwed mothers have been described (Day[2], Sherman[8]). The subject of this paper is group therapy with unwed mothers in an institutional setting.

Members of the group were residents of a home for unwed mothers, supported by religious and charitable contributions. Nearly all of the girls were at least three months pregnant by the time of arrival at the home. Residence in the home was maintained until one week after delivery of the child. Ages of the girls in our group ranged from 12 to 35 years. The majority were in the 16 to 24 age bracket. Their educational backgrounds varied, some having attained only a seventh grade level, while others had completed two years of college or business school. Occupational status of the fathers of the girls ranged from blue-collar workers (the majority) to white-collar workers and several of the professions. Most of the girls came from homes disrupted by parental discord: separation, divorce, or persistent arguing and bickering in the family. Most of the girls whose parents were divorced lived with the mother or with maternal relatives, only a few lived with the father. Girls whose parents lived together frequently expressed resentment toward one or both parents. The mother seemed to be the most frequent target of their hostility.

The relationship of the girls to the putative fathers of their children was most often described as having been a "love" relationship. Most of the girls expressed resentment toward their sexual partners, and a majority did *not* want to resume their contacts with them.

During their stay in the institution the girls were part of a close community, sleeping in rooms with two or three beds each, eating together, and jointly doing the necessary housekeeping chores. There was little or no chance for socializing outside the home. Since the institution was religiously oriented, there were frequent worship services conducted by members of the staff. Although these formal services were reputedly voluntary, considerable emphasis was placed on full attendance.

Group Resistances

We opened the sessions by stating that each girl in the group had feelings and emotions which had influenced her behavior. We said that increased understanding of these feelings would result in a better adjustment during and after her pregnancy. As we progressed,

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certain resistances were predominant which seemed typical of this kind of group and which were dealt with by the technics described below.

Early in the course of the group the girls expected the leaders to give advice. They also requested that we bring fruit and other food so that they could have a party. This attitude derived in part from the girls' feelings of deprivation and the wish to be nurtured. To place the therapists in an advice-giving, directive role offered an escape from having to participate actively and deal with anxiety-producing topics. We re-emphasized that we could help them through exploring their feelings and reactions to pregnancy and their concern about the future. Once we adopted this frame of reference there were fewer demands for advice or "feeding." They generally accepted as genuine our desire to help. The same resistances arise initially in other types of groups, but they were probably intensified in this group because of the specific psychological problems of the mothers.

The question of confidentiality and trust of other group members and of the therapists was a recurrent issue. In this home, the girls knew one another by first names only. Each was reliant on the others' confidence concerning their names, homes, family problems, and so on. While the divulgence of last names and home towns was not encouraged in the group, the girls often discussed personal relationships and feeling toward parents. A crisis arose when one girl told her visiting brother that a girl he knew was residing in the home. This resulted in the isolation and castigation of the indiscreet girl. She did not return to subsequent meetings. Silence and inability of a group to work meaningfully on any topic or theme might be due to the presence of a girl who represents an unknown quantity in regard to confidentiality.

The unwed mothers questioned the motivation of the therapists in meeting with them. We were accused of being voyeurs and of merely wishing to use them as guinea pigs in a study. We indicated that we were genuinely concerned with understanding the problems and feelings which had resulted in their pregnancies and wished to be of help to them in working on whatever problems they felt were important in returning to a normal life following their delivery.

Problem Areas and Defenses

Certain themes and problems kept coming up in the group. The emergence of these themes into conscious awareness and having them put into words frequently aroused feelings of anxiety and sometimes depression. The girls used psychological defense mechanisms to deal with these feelings.

The girls expressed fear and expectation of being rejected for their "misbehavior". This appeared in the sessions in two forms. They persistently attempted to inveigle us into expressing judgmental attitudes toward them. They hoped for approval from us for their behavior, or confirmation of their fears of being unacceptable. While the latter would be painful for them, it would justify their fears and give them the feeling of being able to assess the attitude of society toward them. It seemed that the girls related to the staff — as they did to us — with a preconceived notion that the staff would reject and condemn them.

They also expressed the fear that their unusual absence from home, avoidance of others, and insecurity would undoubtedly reveal their "guilt" of unwed motherhood.

By identifying their fears and expectations rather than confirming or denying them, we enabled the girls to work out more adaptive approaches to adjusting in the community.

The group also debated the positive and negative aspects of telling a prospective husband about their unwed motherhood. Various methods of "sounding out" a prospective husband on his attitude toward pre-marital relations and illegitimate pregnancy were discussed.

There were critical comments about the staff

of the home. The girls frequently tried to play off the therapists against the staff of the home by encouraging us to join in (or condone) criticism of staff members or permit them extra privileges such as smoking during group sessions. (Smoking, except in designed areas, was not allowed.) We assiduously interpreted these tactics in the group. To have gone along with these ploys would have undermined our effectiveness in working with the group members and resulted in a strained relationship with the staff and director of the home. Such neurotic behavior on the therapists' part would have been communicated to members of the staff, thus recreating the neurotic interaction of the families of a number of the girls. The girls related to the staff expecting to be rejected and condemned. Indeed, some of the girls persisted in resistant and provocative behavior calculated to elicit rejection and criticism from the personnel of the home.

Another major topic was the decision whether to give up or keep the baby. We encouraged the group members to explore their own feelings and plans both *pro* and *con*. Interestingly, the consensus was that they would give up the child. When one member expressed a plan to keep her baby, she was quickly set upon by the others who had already decided to give up *their* children. The expression of the intention to keep the child touched on latent, unresolved urges of this nature in the girls who reported that they were giving up their children. In addition, guilt over relinquishing the child might be rather intense and easily provoked, resulting in defensive aggression. Many voiced the feeling that keeping the child in the face of the difficulties for both mother and baby was selfish, since it was obviously motivated by the mother's own psychological need to be loved and needed and not out of consideration for the child.

Some of the girls expressed feelings of remorse and guilt over having had a sexual relationship and resultant pregnancy. There was frequent reference to fear that their conduct would result in God and society rejecting them, and that they would no longer be acceptable within their religion and community. The girls often complained in the group sessions that the religious services in the home were calculated to make them feel guilty and ashamed. There was evidence of distortion because of the sensitivity of the mothers to criticism and rejection, although there may have been unconscious hostility, rejection, and condemnation of the mothers by some staff members in the home. We attempted to reduce the guilt and self-condemnation of the expectant mothers through pointing out that their problems, including their pregnancies, were attributable to feelings, emotions, and needs which were not bad or reprehensible in themselves. In this way we attempted to detoxify the situation in order to support self-esteem and to enable the girls to feel acceptable to themselves while at the same time viewing their behavior and feelings more objectively. We did not feel that the reduction of this moral guilt would make the resumption of an illicit sexual relationship more likely. We assumed that the detoxification of the whole issue of motivation of behavior would result is less conflict and foster the development of more adequate controls through incorporation of the non-judgmental attitudes of the therapists.

Discussion of the motivation of behavior, especially the feelings and motives which resulted in their pregnancies, arose in every session. The feelings of deprivation which we had noted in individual interviews with the girls were frequently verbalized in the group. On many occasions the girls would articulate their strong desire to be cared for and loved, relating this to their attraction to the father of the unborn child. This recognition was reinforced by the group leaders in order to redefine for the girls the events leading to their present situation. We did not attempt to have the group deal in depth with the intrapsychic conflicts and deprivations which resulted in the desire for affection expressed by some of the group members. A number of the group members also voiced the feeling that they might have become pregnant in order to strike out at parents and parental values. Other authors[1, 5], have discussed the desire for affection and the rebellion against parents as fac-

tors in unwed motherhood. Our experience indicated that this group, with a rapid turnover of members in a setting with communal living conditions, is not conducive to development of insight into intrapsychic conflicts. Too, these members are understandably concerned and preoccupied with their pregnancies, their decision whether to keep the baby and their return to the outside community. It is these issues that can be profitably discussed in this type of group.

The group members used several defense mechanisms repeatedly in dealing with their feelings about their pregnancies. They rationalized "everybody does it (extra-marital sexual intercourse) but we just got caught." While this may seem reasonable in the light of recent studies of the sexual habits of American men and women, it has been pointed out[9] that sexual delinquency and unmarried motherhood are not synonymous. The advent of readily available oral contraceptives and enlightenment about reproduction lead one to conclude that unconscious motivation must contribute to unwed motherhood. The putative fathers were blamed by a number of group members since "it was his responsibility to take precautions." This stance served to protect the girl from an awareness and admission of her own responsibilty for her condition. This maneuver represented projection and displacement of blame from themselves. Denial (in the sense of an expressed wish to avoid all awareness of pregnancy) was voiced by several of the group members. In spite of this wish, these members remained in the group and seemed to derive support from the knowledge that others had the same feelings and problems.

Our group members spanned a wide spectrum intellectually, socially, and economically. The more intellectually superior and sophisticated girls were not the ones who consistently attended or appeared able to best utilize the group in working toward reasonable goals. Some of the expectant mothers who appeared to be lower on the intellectual and economic scale told us of having obtained significant help from the group. They appeared less reticent in discussing their feelings and reactions. One of the girls who was best able to verbalize in a moving way her feelings and anxieties and who assumed a respected position of leadership was a former resident of an institution for the mentally deficient.

This group had several distinguishing characteristics. Most of the members were in their teens. Thus, we might reasonably expect it to have some of the characteristics of an adolescent group. However, the major characteristics and group themes were related to their pregnant state. This finding is consistent with experiences of other authors[3, 7], who have noted the introversion and preoccupation of the expectant mother with the growth of the fetus and the forthcoming delivery. Our group was open ended with the introduction of new mothers at every meeting and loss of one or more old members through delivery and discharge from the home. Even a member who attended throughout her stay would be present for only six to sixteen weeks. This, of itself, tended to limit the level of insight that it is possible to obtain in the therapy group. The rapid turnover of group members did not encourage the lowering of established defenses. The communal living conditions influenced the character of the sessions and it was clear that the members thought carefully before criticizing one another because of possible repercussions and isolation by the other member and her friends outside the group sessions.

We found girls with neurotic problems and character disorders among the residents of this shelter. Those who were more neurotically disturbed and who manifested guilt and anxiety seemed to derive more benefit from the group sessions. The more neurotic girls were the same ones who would be adjudged the best psycho-therapeutic candidates had they been seen in the non-pregnant state in a psychiatric outpatient clinic. This is in agreement with Slavson's findings[9] that the condition of unwed pregnancy in itself is no criterion for selection for psychotherapy but that the girl should be selected on the basis of criteria which are applied to any other potential psychotherapy candidate.

The emergence of the theme of indecision about giving up or keeping the baby is of interest since in this home only 50 per cent of the girls gave up their babies for adoption. We do not know what proportion of the girls who gave up their infants were group members. Either those girls who intended to keep their child did not attend the group or the expressed intentions in the group were motivated by a need to conform to group pressure during the sessions but did not carry over after delivery when the desire of the mother to keep the infant was increased by its actual presence. This is an important issue since there is a paucity of trained and experienced caseworkers to work through with the mother her indecisiveness about keeping the child. If this issue can be successfully dealt with in group therapy, then one experienced therapist (not necessarily a psychiatrist or psychologist) might be able to conduct a group with one of the primary goals being the successful resolution of this decision prior to the delivery. When the decision to give up the child has been adequately worked through before the delivery the mother may be better able to see the baby and still maintain her resolution to give it up for adoption.

We hoped to motivate some of the girls to pursue therapy following their discharge from the home. Due to the need for respecting confidentiality, we were not able to obtain a follow up on this issue. Most of the girls had very limited financial and transportation resources at home; or they lived in small towns which did not have nearby psychiatric, psychological, or social services. Many were not sufficiently motivated to continue therapy even if they had available the funds and facilities. It was unlikely that many of the group made a decision to obtain further psychotherapy as a result of the group therapy experience.

Several authors[3, 7] have discussed the profoundly altered physiological and psychological state of pregnant women in the direction of introversion and preoccupation with the fetus and coming delivery. These alterations have been documented by psychotherapists who have followed their patients through the course of pregnancy. A relaxation of previously better functioning defense mechanisms and a lessened repression of highly charged material during normal pregnancy has been described[7]. From the start we were concerned with the possibility of creating tensions and anxiety in these pregnant women which could precipitate psychological disturbances and we wanted to determine whether psychotherapy in a group setting would adversely influence their adjustment. One of the most significant findings of this series of group sessions was that a group with goals such as those enumerated above can be conducted by a skilled professional without generation of undue anxiety on the part of the group members or the precipitation of depressive reactions or other psychiatric symptoms.

A group such as this one proves effective in modifying attitudes of self-blame, restoring a sense of self-esteem, and providing a safe environment in which to ventilate hostility, frustration, and anxiety.

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Three cases of severe iron deficiency anemia are here reported in which a leukoerythroblastotic response followed the parenteral administration of iron dextran.

Leukoerythroblastosis Following Administration Of Iron Dextran

Earl T. Anderson, M.D. and Jerry P. Lewis, M.D./Montclair*

Leukoerythroblastosis in severe iron deficiency of infancy following the administration of iron dextran has been previously reported, but since this is not well known this paper is offered as further evidence of this relationship. These three cases again demonstrate that leukoerythroblastosis need *not* signify a serious hematologic disorder but may be merely a manifestation of an iron deficient marrow responding to parenteral iron therapy.

Case One

A 16-month-old female was admitted to Presbyterian-St. Luke's Hospital because of severe anemia. A three day history of fever to 105, irritability, and anorexia was obtained. The child, born two months prematurely, weighed three pounds at birth. Her dietary habits were poor and she subsisted primarily on milk, grits, mashed potatoes, and eggs. On admission, she was restless, pale, and in moderate respiratory distress. Positive physical findings included heart tones of increased intensity and a grade II/VI systolic murmur which could be heard over the entire precordium. The liver was palpable one and one-half finger breadths below the right costal margin, and the spleen was palpable one and one-half finger breadths below the left costal margin.

Initial laboratory studies included: hemoglobin 4.8 gms/100 ml., hematocrit 20 per cent, reticulocyte count 2.3 per cent, nucleated peripheral blood elements 78,800 (leukocytes 53,400 and nucleated erythroid elements 25,400), and platelet count 28,000. The differential count of the peripheral blood leukocytes was as follows: polymorphonuclear leukocytes 28 per cent, bands 29 per cent, lymphocytes 14 per cent, monocytes 3 per cent, metamyelocytes 18 per cent, and myelocytes 8 per cent. There were 36 nucleated erythroid elements per 100 leukocytes. Of these, 22 were normoblasts, 11 were late erythroblasts, and 3 were early erythroblasts. The red cells exhibited marked anisocytosis and poikilocytosis. The bone marrow was markedly hypercellular with an increased number of megakaryocytes, many of which appeared immature. The myeloid series was active with orderly maturation, and

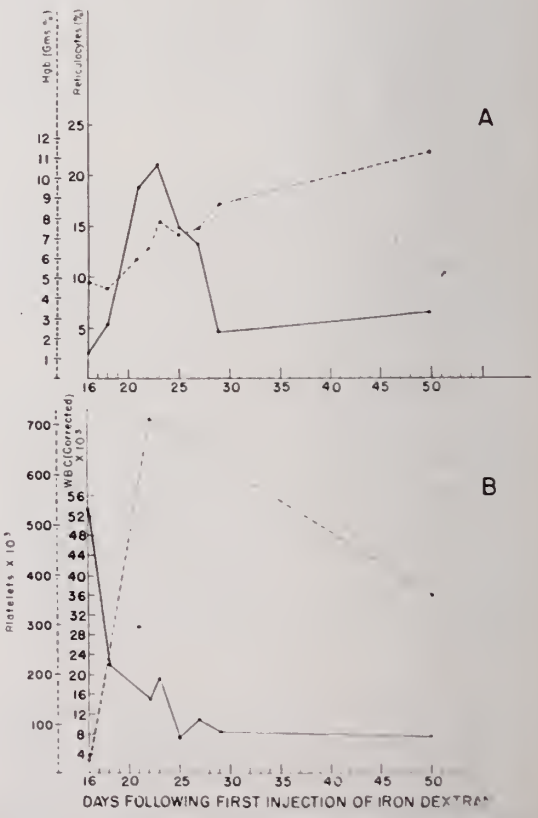


Figure 1—Changes in hemoglobin, retics (A), WBC and platelets (B) in Case #1 following treatment with parenteral iron-dextran.

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the erythroid series was markedly hyperactive with a significant maturation disturbance. The M:E ratio was less than one. Several bizarre reticulum cells and a few clusters of unidentified cells were seen in the bone marrow preparation. These along with the leukoerythroblastotic picture raised the question of a possible primary or secondary malignancy of the marrow. The Prussian blue stain for iron revealed an adequate amount of iron to be present, but the iron was deposited as dense discrete dots.

Additional laboratory studies included a total serum bilirubin of 0.2 mg., serum alkaline phosphatase 1.8 B.L. units, paper hemoglobin electrophoresis at pH 8.6, 100 per cent hemoglobin A, fetal hemoglobin determination 2.8 per cent. Direct Coombs' test was negative, serum uric acid 5.4 mg and BUN was 11 mg. A PAS stain of the bone marrow was done and there was no uptake of the stain by the erythroid precursors.

The child had been seen two weeks previously by a physician who had treated her for a "severe anemia" with three intramuscular injections of Imferon® over a ten day period. It then became clear that this was a case of severe iron deficiency anemia which had developed a striking leukoerythroblastotic reaction consequent to treatment with iron dextran.

The child recovered without sequellae. Serial peripheral blood counts during her hospital course are shown in Figure 1. Without any therapy (except antipyretics) while in the hospital, a peak reticulocytosis of over 21 per cent occurred. This was accompanied by a progressive rise in hemoglobin and platelet count and a return to normal of the peripheral white blood cell count. Large numbers of immature white blood cells and nucleated erythroid elements persisted during the first week of hospitalization and then gradually disappeared. At the time of discharge on the thirteenth hospital day the child was asymptomatic and eating well. Physical examination was within normal limits and the spleen could no longer be palpated. The hemoglobin was 8.6, the white count was normal, and the differential count unremarkable. The patient was maintained on oral iron and was seen four weeks after admission, at which time her hemoglobin was 11.2 gm and the reticulocyte count was 6.4 per cent.

Case Two

A 16 month old female, had a two day history of vomiting. The child was extremely pale. She was the product of a normal delivery and weighed six pounds, 15 ounces at birth. The mother stated that the child seldom ate solid foods, and existed primarily on milk which she consumed at the rate of about one quart per day. On admission, she weighed 20 pounds, four ounces. Positive physical findings were limited to a sinus tachycardia of 160. Hepatosplenomegaly was absent.

Admission laboratory data included: hemoglobin 2 gms., hematocrit 9 per cent, reticulocyte count 0.3 per cent, WBC 6,450, and platelet count 15,500. Red cell constants were: MCV 52 cubic microns, MCH 13 micrograms and MCHC 25 per cent. Bone marrow was active with a striking decrease in megakaryocytes and erythroid elements. The M:E ratio was 4:1. Iron stores were absent.

Because the child's condition was felt not to be critical, she was treated with parenteral iron dextran and not given transfusions. She received a total dose of eight ml. of Imferon® intramuscularly (400 mg. elemental iron) over a period of two weeks. Within 24 hours after the first injection her bone marrow was considerably more cellular and within 48 hours there was a significant reticulocytosis and leukocytosis. The bone marrow differential counts are shown in Table 1 and

TABLE I
Differential* of Bone Marrow Cells From Case II

	DAY FOLLOWING FIRST INJECTION OF IRON DEXTRAN					
Cell Type	0	1	2	3	7	12
Polymorphonuclear Leukocytes	10.0	10.2	7.6	10.3	13.6	5.4
Bands	12.0	20.2	34.6	28.4	11.6	16.6
Metamyelocytes	20.2	21.6	22.4	16.6	5.4	13.4
Myelocytes	16.8	10.6	12.2	11.8	6.0	3.8
Promyelocytes	1.8	3.4	4	5.6	3.4	2.8
Basophiles	0.2					
Eosinophiles	3.2	3.2	3.2	5.6	2.8	7.4
Lymphocytes	14.0	15	3.8	12.8	25.4	33.2
Blasts	2.4	3	2.2	2.8	2.6	3.8
Plasma Cells	1.0	1	.6	.8	2.8	1.0
Reticulum Cells	8.0	7.4	6.4	1.6	11.8	3.4
Monocytes	10.2	4.4	3	3.5	14.6	9.2
Number of Erythroid Elements Per 100 Nucleated Nonerythroid Cells						
Normoblasts	3.0	14.2	23.6	22.8	23.2	36.4
Late Erythroblasts	7.0	14.2	29.6	39.2	32.6	41.0
Early Erythroblasts	6.2	14.4	23.0	14.2	19.0	18
Procrythroblasts	3.6	7.6	11.4	10.0	3.2	3.4
Marrow Parameters						
Myeloid: Erythroid Ratio	3:1	1.5:1	1:1	1:1	1:2	1:2
Megakaryocytes	Decreased	Adequate	Adequate	Adequate	Adequate	Increased
Stainable Iron	0	0	0	0	0	Small Amt.
Marrow Activity	↑	↑	↑	↑	↑	↑

* 500 Nonerythroid elements counted. Results reported as per cent.

TABLE 2
Differential** Of Peripheral Blood Leukocytes From Case II

Cell Type	DAY FOLLOWING FIRST INJECTION OF IRON DEXTRAN***						
	0	4	5	6	9	13	17
Polymorphonuclear Leukocytes	46.4	41.0	49.2	62.8	43.4	29.8	29.4
Bands	3.4	13.2	14.6	14.0	8.0	0.2	2.8
Lymphocytes	41.8	29.2	20.2	10.6	32.0	53.6	55.2
Monocytes	4.6	6.4	6.0	7.8	12.4	12.2	7.2
Eosinophiles	0.8	1.4	2.0	0.2	2.4	1.8	4.2
Basophiles	0.8	1.4	.8	1.0	0.2	2.0	1.2
Metamyelocytes	1.4	5.8	5.8	2.4	1.0	0.4	
Myelocytes	0.6	1.4	0.8	0.8			
Promyelocytes		0.2	0.2				
Blasts							
Number Of Nucleated Erythroid Elements Per 100 Nucleated Nonerythroid Peripheral Blood Cells							
Normoblasts	0.6	1.6	5.2	0.4	0.6	0.2	
Late Erythroblasts	0.2	5.6	4.2	1.8	0.8		
Early Erythroblasts	0.2	0.8	0.6	0.4	0.2		
Total White Blood Cell Count Not Corrected For Circulating Nucleated Erythroid Cells	6,450	23,550	18,800	34,300	6,700		7,300

** 500 Nonerythroid elements counted. Results reported as per cent.

*** 1 ml Imferon given i.m. on the following days: 0, 2, 3, 5, 7, 9, 11, 12

the peripheral blood differential counts in Table 2. Three days following the administration of Imferon® there was a moderate leukocytosis and an outpouring of immature granulocytes including occasional myeloblasts and many nucleated erythroid elements. On the tenth day the white blood cell count had returned to normal and most of the immature cells had disappeared from the peripheral blood.

The peripheral blood response is summarized in Figure 2. A peak reticulocytosis of 21.3 per cent occurred on Day 10, and there was a progressive rise in hemoglobin and platelet count. The patient was discharged on the 15th hospital day with a hemoglobin of 8.9 gms. She was maintained on oral iron as an outpatient, and five and one half weeks following admission her hemoglobin was 12 gms.

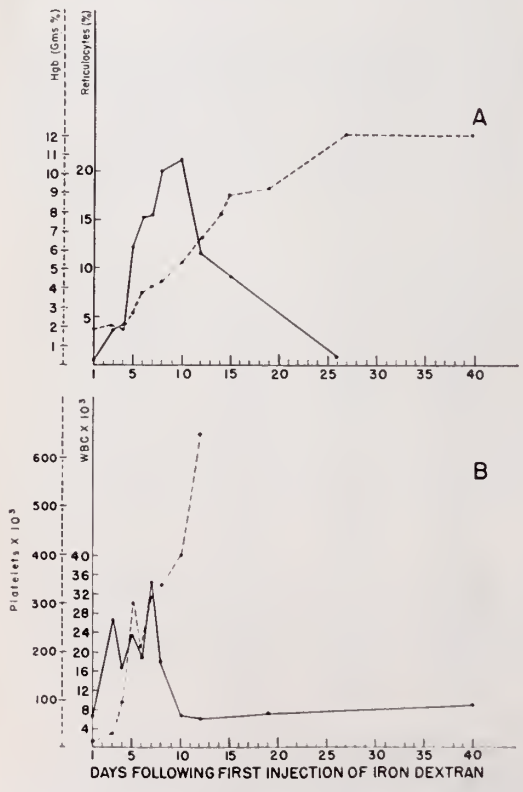


Figure 2—Changes in hemoglobin, retics (A), WBC and platelets (B) in Case #2 following treatment with parenteral iron-dextran.

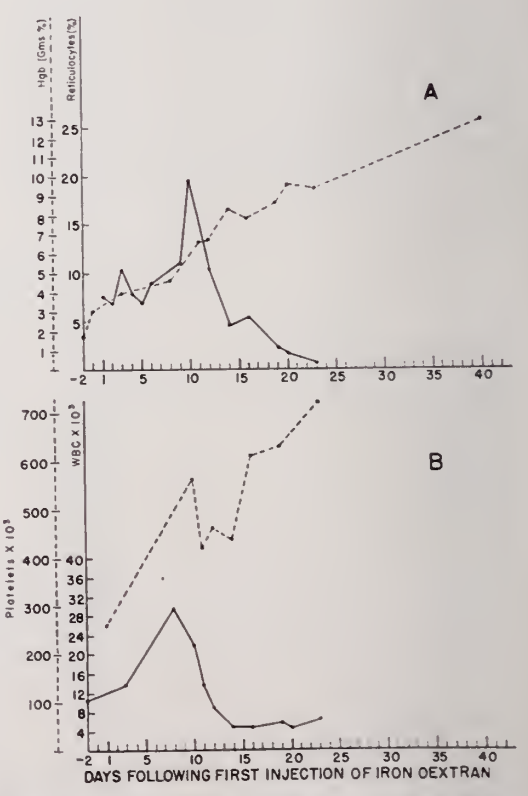


Figure 3—Changes in hemoglobin, retics (A), WBC and platelets (B) in Case #3 following treatment with parenteral iron-dextran.

Case Three

A 21-month-old boy was admitted to Presbyterian-St. Luke's Hospital for evaluation of severe anemia. The patient had been vomiting one to two times a day for three weeks. During this period of time the child had become increasingly more pale and more easily fatigued. He was a product of a full term gestation and normal delivery. The child was breast fed for the first year of life; during his second year he consumed 32 to 40 ounces of whole milk per day with some fruits and vegetables but very little, if any, meat. The child was small but otherwise well developed. He was somewhat lethargic but was in no acute distress. His skin and mucosal membranes were exceedingly pale. Other positive physical findings included a Grade III/VI holosystolic blowing murmur heard best at the apex, a protuberant abdomen, a liver that was palpable three finger breadths below the right costal margin, and a spleen that was palpable two finger breadths below the left costal margin.

Initial laboratory data included: Hemoglobin 1.7 gms., hematocrit 5.5 per cent, reticulocyte count 4.2 per cent, WBC 10,150, and platelet count 260,500. The leukocyte differential count was: polymorphonuclear leukocytes 54 per cent, bands 4 per cent, lymphocytes 41 per cent, and monocytes 1 per cent. The red blood cells were microcytic and hypochromic, and the bone marrow was unremarkable except for an absence of stainable iron.

Because this child was in a rather poor clinical state, he was transfused with packed red blood cells, and starting on the third hospital day, he was treated with Imferon.® He received a total dose of 5 ml. (250 mg. of elemental iron). On the third day of treatment a leukocytosis developed with an outpouring of immature granulocytes including myeloblasts and nucleated erythroid elements. This leukoerythroblastotic picture persisted for approximately ten days. His response to treatment is summarized in Figure 3. A peak reticulocytosis of 19.4 per cent was seen on the tenth day followed by a progressive rise in hemoglobin. Although the platelet count was initially normal, a thrombocytosis developed following Imferon® therapy and eventually reached a level of 700,000. The patient was discharged on the 26th hospital day with a hemoglobin of 9.6 gms. He was placed on oral iron and when seen seven weeks following his admission to the hospital, he had a hemoglobin of 12.8 gms.

Discussion

Iron deficiency anemia is by far the most common hematologic condition encountered in childhood. The diagnosis is usually made with ease, but the presence of atypical features may make the diagnosis more elusive. Our cases demonstrate some of these atypical features.

Cases #1 and #3 demonstrated splenomegaly at the time of admission; Wintrobe[1] has pointed out that splenomegaly may be found in from 10 to 33 per cent of cases of iron deficiency anemia, and Bartlett and Beatty[2] have reported splenomegaly in 17 out of 65 iron deficient children, but this is not a well known finding. It seems highly likely that iron deficiency accounted for the splenomegaly in our cases since it disappeared following Imferon® therapy.

Another atypical feature of iron deficiency anemia is its association with thrombocytopenia. This was seen in Case #1 and #2. Thirty years ago, Heath and Patek[3] made note of an occasional thrombocytopenic state among the more pronounced and chronic states of iron deficiency and Gross *et al.*[4] found 28 per cent of their iron deficient infants to have platelet counts of 170,000 or less. Whereas the lowest platelet count in the latter series was 50,000, our cases had platelet counts of 15,500 (Case #1) and 28,000 (Case #2). The mechanism by which thrombocytopenia occurs is not known. Beutler, Fairbanks and Fahey[5] have stated that iron containing enzymes may be depressed early in the course of iron deficiency, and Zucker[6] has shown that platelets contain iron presumably in enzymes.

Leukoerythroblastotic reactions following the parenteral administration of iron dextran have been previously reported. However such reports have been rare and the reactions not nearly as severe as those observed in our cases. In 1960 Bowman[7] described a leukoerythroblastotic picture in three iron deficient children given iron dextran, and in 1962 Samuels[8] reported a case which developed a similar response following this therapy. Chandra and Bhakoo[9] writing on leukoerythroblastotic reactions in infants mentioned that three of their cases of severe iron deficiency anemia exhibited this type of response. A careful review of their article, however, shows that only one child was iron deficient and that this child demonstrated a leukoerythroblastotic picture prior to iron therapy. Our first case had a nucleated peripheral blood count of 78,800, and Cases #2 and #3 during their erythroblastotic responses spilled myeloblasts into the peripheral blood. Such peripheral blood findings are alarming; indeed, in the case of our first patient who was seen at the height of this response, the possibility of a malignancy involving bone marrow was considered.

In cases #2 and #3, the outpouring of im-

mature cells from the marrow commenced on the third day following parenteral iron therapy and persisted for approximately ten days. This corresponded with a reticulocytosis and with the rise of the platelet count. The sequences of events are similar to those observed in the cases of Bowman[7] and Samuels.[8] We have no explanation for the lag in peripheral blood response seen in Case #1.

Although early reports of the efficacy of parenteral iron attested to its lack of adverse side effects,[10,11] many reports of untoward side effects have occurred since. Local discomfort and staining of the skin at the injection site is by far the most common complaint of patients; however, more serious reactions such as skin rashes,[12] arthralgia,[13] cellulitis with lymphadenitis,[14] and even anaphylaxis and death[15,16] have been reported. The reaction that we have described in this paper is benign. However, if it is not recognized as being compatible with an iron deficient marrow rapidly responding to specific therapy, an extensive evaluation of the patient might be undertaken in an attempt to confirm a suspected diagnosis of a serious hematological abnormality. In this respect, the leukoerythroblastotic picture in the patient responding to parenteral iron can cause undue concern for both the patient and his parents, and can result in an unwarranted extensive evaluation to rule out a potentially fatal disease.

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The Mountainside Hospital

Unethical Mark-up For Laboratory Work

Dr. E. G. Shelley, chairman of the AMA Judicial Council, reminds us that it is unethical for a physician to mark-up a charge made by an outside laboratory and pass the marked-up charge on to the patient. Doctor Shelley cited one bill directed to the Judicial Council's attention for "serology, $7.50; cholesterol, $7.50; alkaline phosphatase, $7.50; complete blood count, $12; sedimentation rate, $6; glucose, $5; urea, $7.50; and uric acid, $7.50."

This battery of tests was done for a charge of $6 to the physician. This, said Dr. Shelley, is an example of marking-up fees and is an unethical practice.

For amebic liver abscess, emetine or chloroquine may not work — or may produce serious untoward effects. In those cases try metronidazole, Dr. Blechman suggests.

Metronidazole In The Treatment Of Amebic Liver Abscess*

Martin G. Blechman, M.D./Hackensack

A standard treatment for amebic liver abscess has been chloroquine. In the usual therapeutic doses, transient headaches, gastrointestinal disturbances, pruritus, and visual disturbances sometimes negate its use. The usefulness of emetine hydrochloride, (an effective agent in both intestinal and extra intestinal amebiasis) is limited by its neuromuscular and cardiac toxicity.

Recent reports of the value of metronidazole (Flagyl®) in amebic dysentry and amebic liver abscess warrants reporting the following case.[1]

A 23-year-old woman was admitted on June 1, 1967 with fever of unknown origin. Four days prior to admission, she developed general malaise, a temperature of 103 to 106, chills, and right shoulder pain. One day prior to admission, there was vomiting. She had lived in Ecuador until two years prior to admission.

Bilateral moist rales were noted at both bases with increased dullness at the right posterior base. There was tenderness to palpation in the right upper quadrant. No hepatic enlargement was noted. Chest x-ray and gallbladder were normal. Electrocardiogram, except for a sinus tachycardia, was normal. She was immediately given aqueous penicillin 600,000 units for three days followed by 10 million units intravenously for an additional three days.

The white blood count on admission was 10,400 with 81 per cent neutrophils and 2 per cent eosinophils. The remainder of the hematogram was normal. The A/G ratio was 1 to 1.77 on serum electrophoresis. Alkaline phosphatase was 30 KA units and the C-Reactive Protein was strongly positive. Throat culture showed diphtheroids and alpha-streptococcus. Urinalysis, including a culture, was negative. Repeated blood cultures were negative. Purged stools were positive for cysts of *Entamoeba coli* and *Trichuris trichiura*.

During the first week of hospitalization, she continued to have fever and her clinical status remained unchanged. On June 8, 1967, the white blood count was 16,000. The initial liver scan on June 13, showed a defect in the right upper and lateral aspects of the right lobe (Figures 1 and 2). On June 14, she was started on emetine. By June 19, she was afebrile and there was less right upper quadrant tenderness. Emetine was discontinued after the acute phase and she was placed on chloroquine, 250 milligrams, but she subsequently developed severe nausea and vomiting. On June 26, this drug was discontinued and she was started on metronidazole, 800 milligrams, three times daily for ten days. A second liver scan on June 27 showed a diminution of the hepatomegaly. The original defect was then less pronounced. Except for some abdominal distress, the patient tolerated the metronidazole well and she remained afebrile. At the time of discharge on July 8, all liver function tests were normal. A liver scan on March 14, 1969 showed the liver to be normal. (Figures 3A and 3B) The patient remained asymptomatic.



Figure 1. June 13, 1967 — Liver scan using I^{131} Rose Bengal, anterior view, demonstrating absence of uptake in the right upper portion of the lobe of the liver.

* This study is from the College of Physicians and Surgeons, Columbia University, New York, and was supported by research grant 2 T01-AI-0005, U.S. Public Health Service, Washington, D.C.



Figure 2. June 13, 1967 — Liver scan using I^{131} Rose Bengal, right lateral view, demonstrating decrease uptake in the upper central portion of the liver.



Figure 3A — Right Lateral

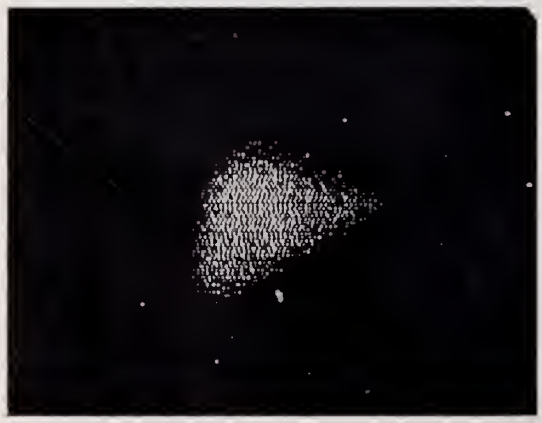


Figure 3B — Left Anterior

Figures 3A and 3B — March 14, 1969 — Liver scan using I^{131} Rose Bengal, anterior and right lateral view, demonstrating normal uptake.

The failure to find *Entamoebae histolytica* in the stool of this acutely ill patient is not unusual. It takes a well trained technician in parasitology to identify the parasite. In addition, it is important to use purged stools. The yield of amoeba will be depressed by antibiotics.

There is a scarcity of material in the American literature on the therapeutic application of metronidazole. Powell[2] treated ten patients in South Africa for hepatic abscess using 2.4 Grams daily for ten days. In a larger series, Powell[3] managed 100 African males with five different dosage regimens. He found no significant toxicity. Kaminsky[4] treated a Vietnam returnee with an amebic hepatic abscess with two Grams of metronidazole daily for 14 days. In the doses used, in the above case, reports[5] indicate that nausea and headache[6] were frequent adverse effects. (Table 1). Vomiting, diarrhea, insomnia, weakness, stomatitis, paresthesia, and rash were occasionally noted. Ataxia was a rare complication. The use of this agent in our patient was justified because of chloroquine sensitivity.

The action of metronidazole on amoeba is not known. Powell[2] suggested that it is a combination of a contact and systemic amoebicidal activity.

TABLE I

Dosage Schedule of Metronidazole in the Treatment of Amebic Liver Abscess

Author	No. Treated	Treatment	No. Cured
Powell[2]	10	800mgm thrice daily for 10 days	10
Powell[3]	20	2.4gm statim followed by 1.2gm six hrs. later then by 800mgm thrice daily for 9 days	20
	20	800mgm thrice daily, 10 days	20
	20	2.4gm statim followed by 1.2gm six hrs. later then by 800mgm thrice daily for 4 days	20
	20	800mgm thrice daily for 5 days	20
	20	400mgm thrice daily for 5 days	20
Kaminsky[4]	1	2 gms daily for 14 days	1
Blechman	1	800mgm thrice daily for 10 days	1

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Dr. Blechman here acknowledges the assistance of Doctor Harold W. Brown for reviewing this manuscript, to Mrs. Concetta Mazzarino, a medical librarian, for her technical help, and to Doctors John Leary and Edward Wagman for the evaluations of the liver scans.

280 Prospect Avenue

PKU Tests May Create Diagnostic Problems

Two problems exist today in the diagnosis of phenylketonuria.

The first problem is the excessive number of false positives indicated with the Guthrie (blood) test. The second problem is the underestimation of PKU incidence when the reagent strip (urine) alone is used for testing.

The Guthrie test gives false positives in large numbers of newborns who are neither true PKUs nor normal. Several other conditions can cause the misleading Guthrie positives. Confirmatory analyses of plasma phenylalanine and plasma tyrosine are needed with positives from either blood or urine testing.

With the Guthrie method infants should be tested on the fifth to seventh day of life, when enough milk protein usually has been consumed to raise the plasma phenylalanine level.

The reagent strip, although remaining a reliable screening test for classical PKU, may be limited by possible inappropriate use by the mother of a newborn. A baby may not be old enough during his first week for phenylketones to appear in his urine, especially if he has not been fed enough protein. The mother might be administering the test incorrectly or there may not be enough urine for her to use with the reagent strip, especially if she uses disposable diapers that collect urine on the back sheet of aborbent paper. Collecting liquid urine with an attachable urine bag increases accuracy.

The reagent strip also is useful to the physician supervising the treatment of a classical PKU patient with diet, but quantitative plasma phenylalanine levels must be used by the physician and the nutritionist to monitor progress, according to Dr. Harry A. Waisman, Professor of Pediatrics, University of Wisconsin Medical Center. It is the responsibility of the physician to test the infant for PKU at two, four, and six weeks of age, using any testing method.

Where laws dictate testing procedures on newborn babies, the common requirement that the baby be tested before it goes home from the hospital is technically in error. Too many infants are discharged on the second or third day after birth, when insufficient milk protein has been consumed to give a meaningful test for amino acids in the blood and urine.

PKU, an inborn error of metabolism that can lead to severe mental retardation, can be corrected with a low-phenylalanine diet. Known for thirty-five years, PKU is now estimated to occur in less than one in 10,000 live births in Caucasians. Even so, the incidence is higher than the one in 20,000 figure estimated in previous years, before mass PKU screening was initiated.

—New York State Journal of Medicine, July 15, 1969

This vivid and first-hand account by Dr. Wiant gives some idea of the tuberculosis problem in Vietnam.

Some Medical Problems In Vietnam

James R. Wiant, M.D./Glen Gardner

South Vietnam is only one of many of the under-developed countries in the world. However, because of our country's military commitment there, Vietnam has received the attention of every American. The size and impact of this *military* commitment has largely obscured the *medical* commitment of the United States to South Vietnam. Historically, this is the largest commitment of medical manpower and medical supplies of one country to another.

Our largest involvements have been the MILPHAP[1] (Military Provincial Hospital Assistance Program) and the support and development of the medical supply system. Two other outstanding assistance programs are operated with the support of the American Medical Association. These are the Saigon Medical School project[2] and the Volunteer Physicians for Vietnam (VPVN). The latter program has sent over 600 American volunteer doctors to Vietnam for 60 day tours. These volunteers work in provincial hospitals helping to treat South Vietnamese civilians.

I recently completed a 60 day tour under the VPVN program. During this stay, I was impressed by the warmth and enthusiasm with which the South Vietnamese people welcomed our medical program. I learned from many non-medical personnel that these are the most significant activities that the United States is sponsoring in Vietnam. Any sustained United States prestige in that country will be governed more by these aid projects than by the military programs.

Medical problems in Vietnam differ from those at home, both in type and in intensity. There are yearly plague epidemics. Typhoid, malaria, and hepatitis are daily problems. War trauma and burns are seen almost daily. The largest public health problem in Vietnam is tuberculosis. The story of Nyugen Tan Tu is illustrative of this problem and reflects the basic deficiencies of the medical care program in South Vietnam.

Nyugen Van Tu, a 54-year-old farmer, came into a dispensary at Gia Linh with a cough he had had for many months. The nurse (Yta) listened to his complaints and gave him some antibiotics on the assumption that he had pneumonia. He did not see a physician, since there is no doctor in Gia Linh. Nyugen Van Tu returned to his two room thatched house which he shares with four children, his wife, and his mother. Two weeks later, he returned to the dispensary in Gia Linh with the same complaints. His temperature was not taken, but he got a different antibiotic from the nurse. In March, he coughed up blood, which took him to the dispensary for the third time. He had been working in his rice fields every day in the two-month interval. Because of his hemoptysis, he was sent to the Provincial Hospital in Quang Tri for a chest x-ray. Quang Tri is 24 kilometers (18 miles) from Gia Linh. The x-ray revealed far advanced active pulmonary tuberculosis. He was admitted to the tuberculosis ward which had 36 beds for patients with tuberculosis. Since there were then 52 patients, he had to share one of the beds with another patient.

Why is Nyugen Van Tan's story typical of the medical scene in South Vietnam? One reason is that some 15 per cent of the population of 16,000,000 people have active tuberculosis. This estimate is based on such facts as the rate of conversion to positive tuberculin reaction. In Quang Tri, the reaction rate in the elementary schools is 10 per cent. In the secondary schools it rises to the frightening figure of 70 per cent. This is in contrast to 18-year old Navy recruits from New Jersey who have a reaction rate of less then 4 per cent.[3]

No mass screening is available. X-ray facili-

ties are seriously limited. Quang Tri Provincial Hospital has a 15 milliampere U.S. Army field unit. This is inadequate for chest x-rays of good clarity. The minimum recommended unit for chest x-rays is 300 milliamperes.[4] The one at this hospital is the only available machine in a province with a population of 300,000 people. In rural areas there is not a single tuberculosis clinic, and there are only a few tuberculosis clinics in the entire country, these being in a few large cities.

South Vietnam has 1,000 physicians most of them under the control of the army. There are only 350 civilian physicians to care for 15,000,000 civilians (1 doctor for 43,000 people). This discrepancy is even more vivid when the universal propensity of doctors to gravitate to the cities is considered. In Quang Tri province, where the Northern border is the demilitarized zone, there is only one civilian physician. Bac-Si (doctor) Tung is on loan from the Army or by choice he would be in Saigon. Bac-Si Tung is in charge of the 400-bed Provincial Hospital. He is the public health chief of the province and is also in charge of the sector dispensaries which perforce are staffed by nurses.

The tuberculosis control problem is further complicated by a lack of antituberculous drugs. Isoniazid, Paraaminosalicylic acid, and Streptomycin are the only drugs available. Because of the communication problem, there are times when even these drugs are not available for brief periods. The backbone of TB control breaks down when INH is not available as happened on two occasions during a recent three-month period. None of the secondary drugs (such as Trecator^{R} and Myambutol^{R}) are available at all.

A further marked deficiency is the lack of laboratory facilities. Currently only smears for acid fast bacilli (AFB) are done in Quang Tri. There are clinicians in the United States who advocate that smears for AFB be abandoned in favor of cultures. But in Quang Tri Province, (as well as in most areas of South Vietnam), AFB cultures are not obtainable. Sensitivity tests against the anti-tuberculous drugs are, therefore, not done. This lack of sensitivity testing is not important today because of the lack of secondary drugs. It will be important when these drugs become available in South Vietnam.

When these conditions are compared with the status of TB control in the United States, the contrast is striking. The volunteer program in the United States has had to broaden its program beyond tuberculosis control because of the lessened morbidity of this disease. In South Vietnam, the problem of tuberculosis is comparable to the problem of tuberculosis in the United States fifty years ago with two notable exceptions. One of these exceptions is the presence today of antituberculous drugs, which we did not have 50 years ago. The second is the availability of BCG vaccine which does and will have a large part in the tuberculosis control program of South Vietnam.[5] The war has contributed to the problems of tuberculosis and also delayed effective solutions. There are questions of security for personnel, for instance. There is the problem of an unsettled and uprooted populace. Another important issue is the lack of medical personnel (nurses, doctors, technicians). Overriding all is the lack of available funds to institute effective action against tuberculosis and the other public health problems.

Nyugen Van Tu and the other one and a half to three million persons with tuberculosis will not be assured of adequate care until more personnel are available to direct and carry out a tuberculosis control program; until there are adequate treatment facilities available; and until there are adequate funds available to insure a decisive program for tuberculosis control.

The World Health Organization has indicated an interest in assisting with a tuberculosis control program in South Vietnam with the cessation of the war.[6] It will take the concerted effort of a large team to effect a solution. We will be called upon to assist in this program with financial support in the future. Even today, a small part of the deficit in the

treatment of civilians is being met through the AMA's Volunteer Physicians for Vietnam program. I urge any doctor who may be interested to get more information from Dr. Charles H. Moseley, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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Sanatorium for Chest Diseases

What Happens To The Mentally Ill Doctor?

To determine how physicians function after hospitalization for mental illness, records of 40 physicians (38 men, 2 women; average age 42 years) treated at a psychiatric facility were studied. A group of 47 other patients with comparable, professional educational background were selected for control.

Final diagnosis for the doctors was schizophrenic reaction (21), affective disorder (6), chronic alcoholism (7), and drug addiction (6). The other group had a wider spectrum of diagnoses. Before illness, the physicians had had better occupational adjustment than the other professionals but poorer community and family adjustments. Twenty-two doctors had had definite difficulties in adjustment prior to onset of recognizable psychiatric illness, and seven more had probably needed care as medical students. In most patients there was no specific precipitating factor for illness. Whatever the diagnosis, they tended to abuse drugs. Twenty-seven entered hospitals voluntarily, and thirteen were committed; nine had significant physical problems. Psychiatric treatment included individual and group psychotherapy, ECT in 25 and psychotropic drugs in 35.

Physicians, more than the other professional patients, took a direct and commandeering interest in management of their cases, as exemplified by their failure to follow through on psychiatric recommendations. They were excessively concerned about memory loss and confusion accompanying ECT. Several of the alcoholics continued to deny illness, although two had suffered brain damage; drug addicts showed typical problems in accepting treatment. Average duration of hospitalization was 121 days, five patients leaving against medical advice.

At follow-up 7 had had a total of 27 more admission to mental hospitals; 11 had returned to stable pre-illness state of practice; 2 were in partnership with another physician who guided and advised; 9 were working in institutional settings; 3 were physically ill and not practicing; 2 had entered less demanding occupations; 3 were long-term hospital patients; 1 had lost his license; 8 were dead, including 5 suicides. Physicians whose functioning was best after illness received considerable support from other physicians; in addition, they participated actively in their own treatment, a few experimenting with psychotropic drugs until they found the best treatment.

—Small, I. F. *Amer. Journ. of Psychiatry.* 125:1333 (March 1969)

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

November 16, 1969

A regular meeting of the Board of Trustees was held on November 16, 1969 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Health Facilities Planning Council . . . Directed that Dr. Louis F. Albright's name be submitted as a nominee for the Board of Trustees of the Health Facilities Planning Council. (Dr. Albright's current term in this capacity expires in January 1970.)

Hearing on State Sanitary Code . . . Stated that MSNJ will be officially represented at a public hearing on a proposed revision of Chapter X of the State Sanitary Code concerning blood banking, to be held in December 1969.

Student American Medical Association . . . Authorized MSNJ becoming a sustaining member of SAMA at an annual membership fee of $100.

Licensing and Regulation of Medical Care Facilities . . . Designated Dr. John F. Kustrup, Sr., of Trenton, as the representative of MSNJ at a meeting to discuss the development of legislation which would encompass the best elements of A-200 and S-301 (both of which dealt with the "certification of need" and other proposals before medical facilities in the State could undertake capital construction programs). A hearing on these bills was held in May 1969 and there was general agreement that it would be necessary to develop another version of the two bills.

Relative Value Index . . . Approved the following recommendation of the Council on Medical Services: (Council had been charged by directive of the 1969 House of Delegates with preparing a revised relative value index.)

That relevant sections of the present Relative Value Index be referred to the appropriate specialty societies, for updating, and that the covering letter stress the necessity for prompt action and state a specific date for reply; otherwise it will be assumed that the present ratios still obtain.

Sensitivity Training Program . . . Approved the following policy statement of the Council on Mental Health concerning sensitivity training programs:

The medical profession has the ethical responsibility to alert the public to certain dangers. The implementation of various processes, which have been loosely grouped under such terms as "Sensitivity Training" (e.g. "T-groups", "Confrontation Groups", "Marathon Sessions", etc.), by group instructional leaders, who are not professionally qualified to recognize hazardous consequences to some of the participants, can lead to the development of psychotic episodes, the activation of pre-existing emotional disorders, marital disharmony, and increase in life tensions, to mention a few. "Sensitivity Training" may be an acceptable tool, but *only* when used by professional experts who are trained in the fields of mental illness and mental health.

Pathology and Cancer . . . Approved, at the suggestion of the Public Health Council, a recommendation of the Committee on Cancer Control that a brief announcement concerning the New Jersey Society of Patholgists' program on pathology and cancer be published in *The Journal.*

Air Pollution . . . Approved, at the suggestion of the Public Health Council, a recommendation from the Committee on Environmental Health concerning the responsibility of states sharing common air sheds (New Jersey, New York, Connecticut, Pennsylvania, and Delaware):

That The Medical Society of New Jersey send a letter to each of the medical societies of these states, *along with a copy of Chapter 13 of the New Jersey Air Pollution Control Code,* urging them to address themselves to their air pollution control commissions or administrations, strongly recommending that the air quality levels for SO_2 and particulate matter be brought into conformity with New Jersey's more stringent code. As a medical fraternity, we share with these states the responsibility for the health and welfare of *the popu-*

lace exposed to common pollutants which are toxic, and consequently consider this a wise prophylactic and preventive health measure.

Public Relations Council . . . Approved the recommendation of the Council on Public Relations that the following continuing projects be approved for 1969-1970:

1. Publication and distribution of:

a. *Junior Health Hints* to schools and public libraries

b. *Membership Newsletter*, including the annual compilation of a bound, indexed set to component societies

c. *Periodic Newsletter* to cooperating agencies/individuals

2. Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business and interests, including:

a. Eye Health Screening Program

b. Annual Meeting

c. Child Safety Week

d. Selected official programs and activities

3. Responsibility for bestowal of the Golden Merit Award

4. Responsibility for the informational center at the annual meeting

5. Urge continuance—or establishment—of orientation programs for new members under the sponsorship of component societies

6. Encouragement of statewide emergency medical care coverage particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates.

At this point, the Council *recommended* that copies of the "Basic Concepts Underlying the Provision of Professional Medical Care" be distributed to the county societies for their use in processing new members through their orientation programs. The Council further *recommended* that a list of specifics for the information and guidance of new members be drafted and circulated for the Council's approval, for ultimate distribution to the county societies to use as a guideline in their orientation programs.

7. Encouragement of Future Physicians Clubs in each county through service as a clearinghouse at state level.

Medical Defense and Insurance — Accident and Health . . . Approved the following recommendation of the Committee on Medical Defense and Insurance and directed that optimum accident and health coverage be made a subject of continuing study by the Committee:

That MSNJ authorize the Nationwide Mutual Insurance Company to underwrite the entire accident and health coverage program for our members.

This action is the result of National Casualty Company's notification to the Blanksteen Agency of its intent to raise the premium level at least 23 per cent for members over 50 years of age. After subsequent discussion, the Nationwide Mutual Insurance Company agreed to issue replacement policies to present National Casualty Company basic policyholders without any age limit and at the present Nationwide rate. However, all basic insurance policies issued in the future would be renewable only to age 70.

Board of Medical Examiners . . . Nominated the following, in the order of preference, for appointment to fill the vacancy on the State Board of Medical Examiners caused by the resignation of Dr. Lloyd A. Hamilton of Lambertville:

John F. Kustrup, Sr., M.D., Trenton
Frederick C. Steller, M.D., Spring Lake
Charles Cunningham, M.D., Vineland

Abortion . . . Referred to the Attorney General for investigation and adjudication activities reported in an article that appeared in *The Bergen Record* (October 30, 1969) and a Channel 7 TV program concerning a minister in East Rutherford and some 30 consultants who have been reported to have arranged more than a thousand abortions in the past eleven months.

Joint Medicare Claims Inquiry Committee . . . Authorized, with the cooperation of the fiscal intermediary for Part B of Medicare (Prudential), the establishment of a Joint Medicare Claims Inquiry Committee, and empowered the President to appoint an appropriate number of physicians as MSNJ members.

Action of the 1969 House of Delegates required the President to appoint a committee to investigate whether Prudential had unilaterally prepared utilization guidelines and was employing them in arbitrarily reducing

physicians' fees in payment of Medicare claims. Under the federal law, the fiscal intermediary has sole responsibility for determining whether a fee is proper. It has access to our judicial mechanism to process a complaint against a member of MSNJ. But the member has no Society-sponsored agency available to him to consider complaints against the fiscal intermediary. This new committee was set up to establish a forum for discussion.

New Jersey Welfare Council . . . Authorized renewal of MSNJ membership in the New Jersey Welfare Council for 1970 and the payment of $25 dues.

Cancer Control And The Society Of Pathologists

The New Jersey Society of Pathologists has been engaged actively in providing assistance to all pathologists in New Jersey in support of their continuing education in cancer:

1. During the past 18 years the Society has conducted seminars to which not only pathologists but all physicians are invited. Notices of the seminars are posted in all New Jersey hospitals. These seminars have been moderated by outstanding authorities in special fields.

2. Study sets distributed to pathologists in the hospitals of New Jersey for the Pathology Seminars are stored with the Tumor Registry of the Society (maintained at present at the Middlesex General Hospital in New Brunswick) and are available to physicians.

3. Colored slides of gross and microscopic features of tumors presented at Annual Seminars are also available for repeated presentation in teaching conferences in Cancer. This material consists of tissue slides, lantern slides, kodachromes, etc., and has been coded for rapid retrieval through punch cards so that a set can be quickly assembled for any particular need. This material includes also printed discussions and analysis of material presented at the previous seminars, and clinical protocols.

4. The Tumor Registry also serves as a clearing house to provide consultation services on difficult problems in cancer diagnosis. The slides are screened at the Tumor Registry Headquarters (at Middlesex General Hospital) and then distributed to recognized authorities for opinion.

5. A program of regional workshops is being organized for the benefit of pathologists in three major areas of New Jersey. Each workshop will be conducted by an authority who will devote himself to a detailed analysis of a selected subject in cancer, discussing problems in diagnosis, prognosis and choice of therapy. Although participation in the workshops will be limited to pathologists and pathology residents at hospitals in New Jersey, the knowledge gained at such workshops will become available to physicians working in these hospitals through their pathologists.

The Workshop Program and other activities of the Registry are now supported in large part by the New Jersey Division of the American Cancer Society.

Unmet Needs: The greatest single need is to motivate all physicians to improve their knowledge of cancer control. The pathologist should be encouraged by clinicians to participate more actively than ever in clinical programs in which he can share his specialized experience with other physicians. The study material in the Tumor Registry of the New Jersey Society of Pathologists should be drawn on abundantly for teaching programs of hospitals and of specialist groups within the state. Much can be accomplished by appropriate publicity directed to clinicians and to directors of medical education. The New Jersey Society of Pathologists can be readily persuaded to provide lecturers from its own ranks in special fields or to aid in recruiting authorities from other states in support of our cancer control program.



News From NJCMD

Medical and dental education came to New Jersey late in its 300 year history, with the establishment in 1954 of Seton Hall College of Medicine and Dentistry. The first classes were admitted in 1956, operating from leased facilities at the Jersey City Medical Center. Those first classes were graduated in 1960, and next spring will commemorate their tenth anniversary with reunion observances.

New Jersey purchased the Seton Hall Medical School assets and assumed responsibility for operation in 1965. The New Jersey College of Medicine and Dentistry enrolled its first classes under that designation in 1966. Shortly thereafter the Trustees recommended that the College move from the leased quarters in Jersey City and develop an extensive modern campus in Newark. An artist's rendering of the proposed new campus forms the masthead for this and future reports to the physicians of our state through these pages.

The College is now operating from interim facilities on the permanent campus site in Newark's Central Ward. Basic sciences, clinical sciences, research, and administration are presently housed in eleven single-story, pre-engineered structures. All medical students are attending classes or engaged in clinical studies in Newark. The dental students will also be in Newark upon completion of the permanent dental center, which is the building at the right in the drawing. Behind it is the teaching hospital, with the medical sciences building in the center and the library and auditorium at the left.

The permanent campus, on its 58 acre tract, is scheduled to be completed in 1973. The complex will include nine major components housed in six structures, including a 125,000 volume library, a 1,000 seat auditorium, central administration, core teaching facilities, animal quarters, basic and clinical science department offices, research laboratories and support space, the dental school, and a 275-bed teaching hospital.

Since July 1968, the College has had full ownership and responsibility for the Harrison S. Martland Hospital, formerly Newark City Hospital. This 650-bed, seventeen-story building is the major clinical teaching and research facility for the College, as well as "family physician" to 90 per cent of Newark's indigent citizens. The 875-bed Veterans Administration Hospital in East Orange is used extensively for clinical teaching and also houses much of the office and research space for the clinical staff.

In August 1969 NJCMD announced its affiliation with Beth Israel Hospital in Newark, which has the most active kidney transplant program in the state and maintains one of the largest artificial kidney centers in the northeast. Plans for affiliations with United Hospital Medical Center and Saint Michael Medical Center are also under way. These affiliations will bring the number of available teaching beds above the 2,600 mark, a figure comparable to any medical school in the country. And more are being considered.

The Graduate School was chartered by the State Board of Education in 1961, and the first candidates for advanced degrees entered the following year. In July 1969, the Graduate School of Biomedical Sciences became a separate and independent school of NJCMD. Advanced courses in anatomy, biochemistry,

microbiology, pathology, pharmacology, and physiology are offered toward degrees of master of science and doctor of philosophy.

As the only four year medical and dental school in the Garden State, the completion of NJCMD's planned facilities will enable us to increase the size of our entering classes for medicine and dentistry by 42 per cent; multiply our $3,000,000 annual research program severalfold; and greatly increase our ability to serve as a patient care referral center and a stimulus toward upgrading health services and increasing the supply of practicing physicians and dentists throughout New Jersey.

We will welcome your questions, comments, or suggestions on topics for our regular contribution to your *Journal.* Please write to Mr. Lee R. Munsick, Director of Professional Relations, NJCMD, 36 Commerce Street, Newark, New Jersey 07102.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Disease during November:

	1969 November	1968 November
Aseptic Meningitis	6	19
Primary Encephalitis	6	2
Post-Infectious Encephalitis	0	0
Hepatitis: Total	210	248
Infectious	174	210
Serum	36	38
Malaria	11	9
Military	10	4
Civilian	1	5
Meningococcal Meningitis	7	8
Mumps	177	228
German Measles	26	25
Measles	9	35
Salmonella	38	36
Shigella	66	12

Current Venereal Disease Branch Recommendations On Diagnostic Methods In Gonorrhea

These recommendations pertain to the diagnosis of gonorrhea in the general medical situation and may not apply to research studies where the diagnostic criteria depend upon the problem under investigation.

MEN—Recommended:

1. Microscopic demonstration of Gram-negative, intracellular diplococci on Gram-stained smear of a urethral exudate constitutes sufficient basis for a diagnosis of gonorrhea in men.

2. Where Gram-negative diplococci cannot be identified on direct smear of a urethral exudate, a culture of the anterior urethra should be done on Thayer-Martin medium. Typical colonies of oxidase positive, Gram-negative diplococci on Thayer-Martin medium constitute sufficient criteria for a diagnosis of gonorrhea.

3. In situations where a test-of-cure is desired, a culture of the anterior urethra should be done on Thayer-Martin medium.

Not Recommended:

1. Fluorescent antibody staining of direct smears of urethral exudates is *not recommended* to diagnose gonorrhea in men.

2. Fluorescent antibody staining of urethral exudates should *not* be used as a test-of-cure and is *not recommended* for this purpose.

WOMEN—Recommended:

1. The recommended procedure for diagnosing gonorrhea in women is to culture the cervix and rectum on Thayer-Martin medium. Typical colonies of oxidase positive, Gram-negative diplococci on Thayer-Martin medium are sufficient criteria for a diagnosis of gonorrhea.

2. In special social, medical-legal, and research situations, sugar fermentation reactions and fluorescent antibody staining may be used to confirm the identification of gonococci from cultures.

Not Recommended:

1. Gram stained or fluorescent antibody stained direct smears are *not recommended* for the diagnosis of gonorrhea in women.

2. The delayed fluorescent antibody culture technic is *not recommended* for the diagnosis of gonorrhea in women.

3. Direct fluorescent antibody stained smears and the delayed fluorescent antibody procedure are *not recommended* as tests-of-cure in women.

SPECIAL SITUATIONS:

Cultures on Thayer-Martin medium are recommended as the diagnostic procedure of choice in special situations such as suspected gonococcal conjunctivitis, arthritis, or septicemia. These cultures should be confirmed by sugar fermentations and fluorescent antibody staining. Fluorescent antibody staining of direct smears from conjunctivae, joint fluids, or skin lesions can be used as an adjunct in the diagnosis of these uncommon manifestations of gonorrhea. However, conjugates are being check-tested only for specificity for confirmatory tests on organisms growing on Thayer-Martin medium and not for staining of direct smears.

Medicredit

An American Medical Association spokesman has outlined the AMA's voluntary national health insurance plan, *Medicredit*. Dr. Russell B. Roth, speaker of the AMA's House of Delegates and a practicing physician in Erie, Pennsylvania, said the plan, which would be financed in part by federal income tax credits, is flexible and would assure all Americans of adequate health care protection.

The AMA is on record in its belief that it is the basic right of every citizen to have available to him good health care. Here is a plan which is universal in scope, voluntary in nature, and realistic in terms of program cost.

Dr. Roth estimated the program would cost the federal government $8 billion to $9 billion a year, but about $3 billion a year of that would be offset by liquidation of the medicaid program. Medicare would continue.

"For those in low-income categories, this protection is theirs without expense or contribution on their part," Dr. Roth said. "For those with moderate and higher levels of income, *Medicredit* provides a system of cash incentives to enable them to protect themselves against major health care costs."

The AMA plan calls for establishment of a Health Insurance Advisory Board to create *Medicredit* guidelines. This Board would review the effectiveness of the program and file annual reports.

Basic medical benefits of *Medicredit* would include: (1) Up to 60 days of inpatient hospital services, including maternity services; (2) All emergency room and outpatient services provided in the hospital; and (3) All physicians' fees wherever service performed.

The Ethics Of Paying A Bonus

May a physician pay his employee a year-end bonus based upon a percentage of his increased income for the year? No. A recent AMA Judicial Council opinion states that while it may be customary for a physician to reward his employees for their greater or more efficient services through the year, he may not promise a bonus based upon a percentage of his increased receipts.

The Judicial Council emphasized that basing a bonus upon a proportion of receipts would constitute fee-splitting, a practice which universally is denounced in all forms by the medical profession. A physician, however, may take his increased receipts into consideration in determining the amount of the bonus he wishes to pay his employees, the Council stated.

Seventy Years Of Aspirin

As far back as Hippocratic times, willow bark (which contains salicin) was known as an effective medication. Hippocrates prescribed willow leaves to ease the pain of childbirth. Aspirin was first synthesized in 1853 by Charles Frederick von Gerhardt, a pioneer in organic chemistry, through a process of acetylation. The new salicylate remained a laboratory curiosity until 1876, when it was discovered that salicylates had antirheumatic as well as antipyretic qualities. In that year MacLagan of Scotland published his observations on his use of salicylate in the treatment of eight cases of rheumatic fever. "The results," he reported, "exceeded my most sanguine expectations." Still aspirin was not commercially available to the general public. In 1898 Felix Hoffmann came across Gerhardt's discovery of aspirin. He persuaded his arthritic father to try it and found that the elder Hoffmann's pain and rheumatic stiffness were relieved. At the turn of the century, after many medical papers on the subject of aspirin, the new drug was introduced in the United States by The Bayer Company.

The American Rheumatism Association now says: "In a considerable proportion of patients, aspirin is the only drug needed. . . . Either in the form of aspirin or sodium salicylate, the salicylates are today's most useful drugs in the treatment of rheumatoid arthritis. Its capacity to suppress the symptoms and often the signs of chronic inflammatory articular disease is extraordinary and is usually clearly recognized by the patient himself."

Sometimes when an arthritic patient is told by his physician that the most useful medication for his ailment is well-known aspirin, he may think that his doctor is just trying to get rid of him. This is an unfair conclusion.

"Because aspirin is so widely used and easily available," points out the Arthritis Foundation, "because so many people take it for headache and the common cold, and because it can be bought without a prescription, it has been downgraded in peoples' minds. The fact is that aspirin has a very special and helpful effect in rheumatoid arthritis." The very simplicity of aspirin for treatment is sometimes a deterrent to patients suffering from rheumatoid arthritis. "One of the most disconcerting things about recommending aspirin is that people can't believe anything so inexpensive and easily available can be of much value."

No one really knows just how it works. One theory advanced by Drs. O. Donald Chrisman and David P. Simmons, of Yale Medical School, is that salicylates "significantly inhibit the ability of saline extracts of human articular cartilage to decrease the viscosity of chondromucoprotein." That is, aspirin tends to arrest the progressive degeneration or breakdown of cartilage and thus alters the advance of osteoarthritis.

In the judgment of the Arthritis and Rheumatism Foundation, aspirin is among the safest drugs for the treatment of arthritis.

The National Institute of Arthritis and Metabolic Diseases refers to aspirin as one which the patient "may tolerate with the slightest inconvenience."

The occasional patient who suffers a gastritis when he swallows aspirin is usually protected against this if he takes the tablet with milk or with solid or semisolid food. The tinnitus which may occur if ingestion is excessive is actually a usable indicator since it points up the dosage ceiling for that patient.

All this in only 70 years! It is hard to realize that against the long and honorable history of medicine, aspirin has been with us so short a time.

204th Annual Meeting
May 16-19, 1970
Chalfonte-Haddon Hall
Atlantic City

ANNOUNCEMENTS

Clinical Application Of Basic Sciences

The Burlington County Memorial Hospital series on Basic Sciences and Clinical Applications will present the following program for February:

February 5—"Diagnosis of Genitourinary Lesions"

February 12—"Chronic Renal Insufficiency"

February 19—"Renal Transplantation"

February 26—"Computers in Medicine"

The meetings are held in the T. J. Summey Building at the hospital and convene promptly at 3:30 p.m. AAGP gives credit of one and one-half points per session. For registration and further information, please write to Dr. J. R. Wolgamot who is Director of Medical Education at the Burlington County Memorial Hospital (175 Madison Avenue, Mount Holly 08060).

February In Florida

Registrations are being accepted for Frontiers of Medicine 1970 to be held in Lakeland, Florida, February 18, 19, and 20. Sponsored by the Lakeland Graduate Medical Assembly, this is approved by the American Academy of General Practice for 14 hours elective credit.

A versatile and interesting spectrum of current medical topics is offered by this year's Frontiers of Medicine program with a star-studded guest faculty from the four corners of the United States.

Co-sponsors of the Frontiers meeting—which last year was highlighted by Drs. Christiaan Barnard and Denton Cooley—are the medical staffs of Winter Haven Hospital and Bartow Memorial Hospital. The registration fee is $100. For details, write to the Lakeland Graduate Medical Assembly, P.O. Box 2335, Lakeland, Florida 33830.

Medical Student Scholarships

Applications are now being accepted for the Allen Memorial Scholarships, open to junior and senior medical students in the United States and Canada. The scholarship provides three months of cardiovascular study at the Mayo Clinic, plus an award of $1,000. Deadline for applications is April 1st, with notification May 1. For more information, write to the Minnesota Heart Association, 4701 West 77th Street, Edina, Minnesota 55435.

Radiology Courses

Columbia University announces two special graduate courses in radiology. One deals with recent advances in intravenous urography, and is identified as Radiology PM 8. This is a two-day course, April 9 and 10, 1970, and is held at the Alumni Auditorium, 630 West 168th Street, New York.

The other course is in gastrointestinal radiology, known as Radiology PM 7. It will also be held in the Alumni Auditorium, and the dates are May 6, 7, and 8, 1970. The program will include basic principles and recent advances in this field of radiology.

For further details, write to the Associate Dean of the College of Physicians and Surgeons at 622 West 168th Street, New York, New York 10032.

Jersey Journalist Wins National Anesthesiology Award

The American Society of Anesthesiologists announces that first prize in their journalism award competition went to Mrs. Ruth Winter of the *Newark Star-Ledger*. This was for her distinguished "Special Report on Anesthesia." Mrs. Winter's husband, Arthur, is a member of The Medical Society of New Jersey.

Soviet Medical Tour

During the week of April 10, 1970, you will have the chance to participate in a medical program in Moscow and Leningrad. If you can take two weeks, the tour can be extended to include Hungary and Czechoslovakia. Cost of the one-week tour is $495 and of the extended tour, $775. The cost includes air transportation to and from New York City, meals and first-class hotel accommodations. If interested, write to Perry Elfmont, M.D. at 235 East 57th Street, New York 10022.

World Congress Of Obstetrics And Gynecology

New York will be the site of the next annual Congress of Obstetrics and Gynecology. The meetings will be held during the week of April 12. Some 70 societies in these specialties have united to form the International Federation of Obstetrics and Gynecology, and this Federation sponsors the international meetings. Hundreds of papers are listed, and translations will be offered in the four official languages—German, French, English, and Spanish. Subjects cover the range from maternal physiology to social problems; from precancerous lesions to perinatal influences in child development; and from problems in adolescence to the use of computers in history-taking. An unusual set of exhibits—educational, commercial, and technical will be offered. For more information, write to the World Congress of Gynecology and Obstetrics, 79 West Monroe Street, Chicago, Illinois 60603.

Proctologists Meeting In Spain

The 22nd Annual Congress and Teaching Seminar of the International Academy of Proctology will be held May 13 to 22, 1970, in Spain. A cordial invitation is here extended to proctologists and gastroenterologists to participate in the scientific sessions of the meeting by presentation of a paper. Doctors from many parts of the world will be participating and sessions are open to all physicians who desire to attend.

Arrangements for European meetings must be completed well in advance of departure date. A deadline date of January 31 has been set for all registrations. Full information may be obtained from the Academy of Proctology, 147-41 Sanford Avenue, Flushing, New York 11355.

OBITUARIES

Dr. Horace O. Bell

Most doctors in the Essex County area will remember Horace Bell, who for many years was identified with the institution then known as the Essex County Isolation Hospital or "Soho." Dr. Bell was a pediatrician and epidemiologist who was active in many aspects of public health and contagious disease work. He was a graduate of the medical college of the University of Virginia in the class of 1920. He retired from the Essex County Hospital five years ago and was 74 years old at the time of his death on August 23, 1969.

Dr. John Catapano

On November 9, 1969, John Catapano, M.D., died at the age of 68 after a long illness. An alumnus of the medical school of the University of Naples (class of 1932), Dr. Catapano was a general practitioner in the Ridgefield and Ridgefield Park areas. He was on the staffs of both Holy Name and Hackensack Hospitals and was active in committee work with our Bergen County Medical Society.

Dr. Edward H. Crystell

At the grand age of 86, Dr. Edward H. Crystell, for many years one of the best known general practitioners of northern Essex County, died on October 4, 1969. Dr. Crystell was on the staff of the Passaic General Hospital and years ago was active in the affairs of the Academy of Medicine of New Jersey. He received his M.D. at the old Long Island College Hospital, now the Downstate Medical College, in 1906. Dr. Crystell retired from active practice some years ago.

Dr. John H. Doyle

Born in 1909, John H. Doyle, M.D., of Jersey City died November 6, 1969. He was graduated in 1938 from the medical school of Georgetown University and was affiliated with both the Jersey City Medical Center and the Fairmount Hospital. Dr. Doyle was a general practitioner.

Dr. Rita Finkler

Rita Finkler, M.D., was one of our state's pioneers in gynecologic endocrinology. Born in 1888, she earned her M.D. in 1915 at the Women's Medical College in Philadelphia. After a few years of general practice, she became interested in the concepts of gynecologic endocrinology that were just beginning to burgeon in the early 1920s. She was appointed to the staff of the Newark Beth Israel Hospital and established her specialty's division there. Dr. Finkler was active in committee work for the Essex County Medical Society, and in maternal and child welfare programs in numerous civic activities in northern New Jersey. She died on November 8, 1969, at the age of eighty.

Dr. Z. Lawrence Griesemer

On November 24, 1969, Z. Lawrence Griesemer, M.D. of Elizabeth, died in his 86th year. Dr. Griesemer was an early ophthalmologist, one of the first, indeed, to win the American Board diploma in our state. He was a major contributor to the establishment and maintenance of the ophthalmologic service at the Elizabeth General Hospital. He received his M.D. degree at Columbia University's College of Physicians and Surgeons in 1913, and was active for many decades in the American Academy of Ophthalmology and Otolaryngology.

Dr. Meyer M. Hamburg

Death came on the first day of October, 1969, to Meyer H. Hamburg, M.D., a Highland Park general practitioner who was 74 years old at the time of his death. Dr. Hamburg was a family doctor, well-known in the New Brunswick-Perth Amboy area, and was on the staff of the Perth Amboy General Hospital. He was a member of the class of 1917 at the Medical School of Tufts University, and was active in civic affairs in Highland Park and in committee work for the Middlesex County Medical Society.

Dr. Lloyd Hamilton

In Hunterdon County, Lloyd Hamilton was, indeed, Mr. Medicine. Born in 1896, he was in the class of 1920 at the Jefferson Medical College. He had previously served his country during World War I. Dr. Hamilton was, and always remained, a family doctor of the old school. In Lambertville he was police surgeon, school physician, member of the board of health, and fire department medical officer. He was on our State Board of Medical Examiners, and four times, he was President of the Hunterdon County Medical Society. He was an early member of the Board of Managers of the New Jersey Neuropsychiatric Institute, and a charter member of the staff of the Hunterdon County Medical Center—later President of its Board. Dr. Hamilton died on Thanksgiving Day, 1969, at the age of 73.

Dr. Francis T. Irwin

The busy life of Francis T. Irwin, M.D., came to a sudden end on November 15, 1969, with his unexpected death from a coronary attack. A graduate of the Medical School of Trinity College in Dublin, Ireland, he received his M.D. there in 1937. Dr. Irwin returned to the United States in 1938 and

entered private practice. In 1942 he accepted a commission in the Army of the United States and served throughout the war. On returning to Caldwell, he set up a general practice there, and was affiliated with St. Vincent's Hospital in Montclair. Always interested in the emotional aspects of illness, he joined the staff of the Essex County Overbrook Hospital in 1964, and took graduate work in psychiatry there without abandoning his interest and skill in general practice. Born in 1906, he was 63 at the time of his death.

Dr. Darwin A. Leuzzi

Born in 1910, Darwin A. Leuzzi, M.D., died on November 9, 1969 at the untimely age of 59. Dr. Leuzzi earned his M.D. degree at the University of Rome where he was in the class of 1938. After several years of general practice, he devoted himself increasingly to otology, ophthalmology, and laryngology and was affiliated with St. Mary's Hospital in Hoboken and the North Hudson Hospital in Weehawken. Dr. Leuzzi was a member of the Hudson County Medical Society.

Dr. Herbert R. Mores

Herbert R. Mores, M.D. was a family doctor of the old school who was on the senior staff of the Hackensack Hospital. He had been born in 1904, and died on November 3, 1969 at the age of 65. In 1934 he received his medical degree at the University of Edinburgh. Dr. Mores served with the Army of the United States between 1942 and 1945. His office was located in Hackensack.

Dr. Edward P. Levine

Born in 1899, Edward P. Levine, M.D., was in the class of 1924 at the Medical School of Yale University. After a brief period of general practice, he began to devote himself more to dermatology and syphilology, and served in that capacity both the Newark Beth Israel Hospital and the Clara Maass Hospital in Belleville. Dr. Levine was active in the American Academy of Dermatology and in the American Urologic Association. He died on November 22, 1969, at the age of 70.

Dr. Jacob M. Stein

Word has just been received of the death on March 1, 1969 of Jacob M. Stein, M.D., one of Hudson County's senior practitioners. He was born in 1885, during the first administration of Grover Cleveland, and was 84 years old at the time of his passing. Dr. Stein was a 1915 Bellevue graduate and was a general practitioner affiliated with the North Hudson Hospital in Weehawken. He served on active military duty from 1942 (when he was commissioned at the age of 57) until 1945. Dr. Stein practiced in Weehawken and was proud to be called a family doctor. He belonged to the Hudson County Medical Society.

Dr. Walter Strauss

On November 29, 1969, at the untimely age of 58, Walter Strauss, M.D., died after a brief illness. Born in Germany in 1911, he was admitted to the medical school of Basel, Switzerland, in 1930 at the age of 19—the youngest in his class. He received his M.D. degree there in 1934, and soon thereafter emigrated to the United States, settling in Mercer County. For a quarter of a century he served the people of the Delaware Valley from his office in Trenton. He was a general practitioner on the staff of the St. Francis Hospital, Trenton.

Dr. John A. Sullivan

A distinguished New Jersey medical career came to a close on November 16, 1969 with the death that day of John A. Sullivan, M.D. Born in New York City in 1910, he was graduated from the medical school at McGill in 1937. He did graduate work in gynecology and obstetrics, and soon became a board diplomate in those specialties. Dr. Sullivan became chief of the obstetrical service at the Holy Name Hospital in Teaneck and was a consulting gynecologist to Bergen Pines in Paramus. He became interested in flight medicine early in his career and was active for several decades in the Aerospace Medical Society. He was a captain in the U. S. Air Corps (when it was part of the Army) during World War II and won several decorations for his activity with the 767 Bomber Squadron.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

January

14 **St. Michael's Medical Center**
Newark
Portal Hypertension, Surgery vs. Medical Management

14 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

15 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Medical Management of Gastrointestinal Hemorrhage

21 **St. Michael's Medical Center**
Newark
New Concepts in Rheumatology

22 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Gastrointestinal Hemorrhage

22 **Academy of Medicine of New Jersey**
Section on Radiology
Bloomfield
Interesting X-rays of the Month

22 **Gloucester County Medical Society**

22 **Morris County Medical Society**

26 **Academy of Medicine of New Jersey**
North Hudson Hospital
Weehawken
Symposium: Chemotherapy of Cancer

26 **Cape May County Medical Society**

28 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Symposium on Hypnosis in Medicine

28 **Academy of Medicine of New Jersey**
Mountainside Hospital
Montclair
Symposium on Arrhythmias

28 **Academy of Medicine of New Jersey**
Section on Urology
Dinner Meeting

27 **Hunterdon County Medical Society**

28 **St. Michael's Medical Center**
Newark
Control of Acid Base Balance

29 **Burlington County Memorial Hospital**
Mount Holly
Indications and Technics for Urinary Diversionary Procedures

February

3 **Hudson County Medical Society**

4 to Apr. 29 **Muhlenberg Hospital**
Plainfield
Graduate Course in Medicine
Part II—Respiratory Diseases

4 **St. Michael's Medical Center**
Newark
Uric Acid Metabolism and Gout

5 **St. Joseph's Hospital**
Paterson
Program on Stroke

5 **Burlington County Memorial Hospital**
Mount Holly
Angiographic and Echographic Diagnosis of Genito-Urinary Lesions

10 **Bergen County Medical Society**

10 **Cumberland County Medical Society**

11 **Academy of Medicine of New Jersey**
Rutgers—Student Center
Newark
Symposium on Immunology

11 **Middlesex County Medical Society**

11 **Ocean County Medical Society**

11 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

11 **St. Michael's Medical Center**
Newark
Physical Diagnosis Reviewed

12 **Burlington County Memorial Hospital**
Mount Holly
Renal Transplantation

14 **Academy of Medicine of New Jersey**
Section on Anesthesiology
St. Barnabas Medical Center
Livingston
"Pulmonary and Arterial Sampling"

17 **Warren County Medical Society**

18 **St. Michael's Medical Center**
Newark
The Kidney: Commonly Used Tests; Applications for Management

19 **Burlington County Memorial Hospital**
Mount Holly
Renal Transplantation: Indications and Technics

19 **Gloucester County Medical Society**

19 **Morris County Medical Society**

26 **Academy of Medicine of New Jersey**
Section on Radiology
Bloomfield
Interesting X-rays of the Month

26 **Academy of Medicine of New Jersey**
Section on Anesthesiology
Orange Memorial Hospital
Orange
"Epidural Block Anesthesia"

26 **Burlington County Memorial Hospital**
Mount Holly
Computers in Medicine

March

3 **Hudson County Medical Society**

5 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Treatment of Lymphomatous Disease

7 **New Jersey Society of Anesthesiologists**
Cherry Hill Inn
Cherry Hill
11th Postgraduate Seminar

10 **Academy of Medicine of New Jersey**
Section on Dermatology and
New Jersey Dermatological Society
Paterson General Hospital
Paterson

10 **Bergen County Medical Society**

11 **Middlesex County Medical Society**

11 **Ocean County Medical Society**

11 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

11 **St. Michael's Medical Center**
Newark
Endocrine Review

12 **Academy of Medicine of New Jersey**
John E. Runnells Hospital
Berkeley Heights
Symposium: Pulmonary Embolism

12 **Burlington County Memorial Hospital**
Mount Holly
Recent Advances in the Treatment of Leukemia

18 **Academy of Medicine of New Jersey**
Colloquium on Suicide

19 **Burlington County Memorial Hospital**
Mount Holly
Chemotherapy of Disseminated Solid Tumors

19 **Academy of Medicine of New Jersey**
Somerset Hospital
Somerville
Symposium: Hypnosis in Medicine

19 **Gloucester County Medical Society**

19 **Morris County Medical Society**

20 **Academy of Medicine of New Jersey**
Cooper Hospital
Camden
Symposium: Pulmonary Problems

21 **Academy of Medicine of New Jersey**
Section on Anesthesiology
Orange Memorial Hospital
Orange
"Therapeutic Block for Pain of Carcinoma"

23 **Academy of Medicine of New Jersey**
North Hudson Hospital
Weehawken
Symposium on Emergency Room Care

24 **Hunterdon County Medical Society**

26 **Academy of Medicine of New Jersey**
Section on Radiology
Bloomfield
Interesting X-rays of the Month

26 **Burlington County Memorial Hospital**
Mount Holly
Differential Diagnosis of the Polycythemic States

30 **Cape May County Medical Society**

April

2 **Burlington County Memorial Hospital**
Mount Holly
Management of Painful Syndromes of the Head and Neck

2 **St. Joseph's Hospital**
Paterson
Program on Stroke

8 **Academy of Medicine of New Jersey**
Hoffmann-LaRoche
Nutley
Symposium: "Surgical Management of the Mind"

8 **Middlesex County Medical Society**

8 **Ocean County Medical Society**

8 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

9 **Burlington County Memorial Hospital**
Mount Holly
Rheumatoid Arthritis: Current Concepts of Differential Diagnosis and Management

10 **Academy of Medicine of New Jersey**
Cooper Hospital
Camden
Symposium: Hypnosis in Medicine

10 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Symposium: Pulmonary Problems

14 **Bergen County Medical Society**

14 **Cumberland County Medical Society**

15 **Academy of Medicine of New Jersey**
Section on Dentistry
Veterans Administration Hospital
East Orange
Symposium: "Preventive Dentistry"

16 **Burlington County Memorial Hospital**
Mount Holly
Fits, Faints, and Funny Turns

16 **Gloucester County Medical Society**

16 **Morris County Medical Society**

23 **Burlington County Memorial Hospital**
Mount Holly
The Significance of Hypoglycemia

30 **Burlington County Memorial Hospital**
Mount Holly
Definition, Etiology, and Classification of Congestive Heart Failure; The Pathology and Dynamics of the Failing Heart

May

5 **Hudson County Medical Society**

6 **New Jersey Heart Association**
Rutgers
New Brunswick
Myocardial Infarction and Drug Therapy

6 **St. Michael's Medical Center**
Newark
Controversies in Management of Heart Problems

7 **Burlington County Memorial Hospital**
Mount Holly
Evaluation and Medical Management of Acute and Chronic Heart Failure

12 **Bergen County Medical Society**

13 **Ocean County Medical Society**

13 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

14 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Heart Disease and Selection of Patients for Heart Transplant

16-19 **The Medical Society of New Jersey**
Chalfonte-Haddon Hall
Atlantic City
Annual Meeting

21 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Management of Pulmonary Embolic Disease

21 **Gloucester County Medical Society**

21 **Morris County Medical Society**

25 **Cape May County Medical Society**

27 **Academy of Medicine of New Jersey**
Annual Awards Dinner

27 **Middlesex County Medical Society**

BOOK REVIEWS

The Ophthalmic Assistant. H. A. Stein, M.D. and B. J. Slatt, M.D. St. Louis, 1968, Mosby. Pp. 406. Illustrations 550 ($19.50)

In this well-written, interesting, and informative book many facts are presented in concise and easily understandable fashion. The text starts with a brief, straightforward account of the anatomy and physiology of the eye. Also included is good material on optics. Photographs here — and elsewhere as well — are profusely used and well arranged.

The next section takes us through features of history taking and then the external examination. The principles of use of many of our instruments are explained. An interesting little chapter tells the assistant what conditions should be considered as "emergency," "urgent," "same day" or "priority." The chapter on visual aids is valuable and may be read with profit by the ophthalmic assistant's boss. Indeed, the same may be said of the presentation of the problems relating to the blind and the reading difficulty.

The ideal ophthalmic assistant should be well acquainted with the concepts presented within the light green covers of this book. Those of us in New Jersey, however, are not legally permitted to use all of the talents of such an assistant. How much more efficiently we could practice and how much better for patient and physician if we could only utilize all the help so well set forth in this book! S. Jerome Greenfield, M.D.

Diagnosis and Management of Pain Syndromes. Bernard E. Finneson, M.D. Philadelphia 1969. Saunders. Pp. 337 with 207 illustrations. ($12.50) Ed. 2.

Pain sends people to doctors more often than any other symptom. In 1962, Dr. Finneson, a Pennsylvania neurosurgeon, wrote a book on the management of pain and pain syndromes. It had a swift and well merited success and this is the second edition.

The text opens with a practical discussion of the physiology and psychology of pain. Attention is given to the emotional factors without going overboard on psychodynamics. A new chapter by Arthur Grollman discusses the available anodynes with enough of the biochemistry, pharmacology, and toxicology to give the material a scholarly yet usable dimension. A 22-page chapter on headache is a veritable monograph on this subject. Pain is discussed regionally — backache, facial pain, and the like. The syndromes are also reviewed physiologically in terms like pain in peripheral vascular diseases, intractable pain in malignancy, and autonomic reflex pain. The advice given to the readers is not simply a review of the medications available, but also a guide to the whole area of "managing" the patient whether it be by braces, psychiatric help, surgery, analgesic blocks, or any other method. The book is elegantly and usefully illustrated by line drawings made by Barbara Finneson (the author's wife) which clarify many of the points at the usual ratio of one picture being worth a thousand words.

All in all, this is a valuable guide to any physician concerned with handling the patient in pain. And what doctor isn't? Abraham Leff, M.D.

The Artificial Kidney. (Vol. 1). Yukihoko Nose, M.D. St. Louis, 1969, Mosby. Pp. 343. Illustrations 401. ($27.75)

Here is an atlas type presentation describing all aspects of hemodialysis. Dr. Nose includes specific directions and over four hundred carefully detailed drawings, taking the reader step by step through hemodialysis. The book is written in a form that is both easy for physician and patient to understand. It can therefore be used to explain many of the questions which patients may ask.

Although the title of the book is *The Artificial Kidney* the emphasis is placed upon the various technical procedures involved in hemodialysis and in illustrations of commonly used apparatus. It is particularly clear on the illustration of various types of A-V-shunts.

All the various forms of equipment and data are available in detail in this volume. The author has meticulously explained the operation of various facilities for home dialysis and has presented it in a manner which is easy to understand. This manual can be used for home dialysis patients and their families so that they may more adequately cope with this challenging problem. The biography is up-to-date, the charts are clear, large, and easy to understand. This volume fills a real need in the management of the patients requiring repeated hemodialysis.

Joseph J. Kinney, M.D.

Medical Supply in World War II. Edited by Colonel Robert S. Anderson, M.D. and C. W. Wilste, Ph.D. Washington, D.C., 1969. Superintendent of Documents. Pp. 662 with 149 illustrations, and 52 maps. ($8.25)

For those who served in the Medical Department of the U.S. Army during World War II and were concerned about chronic shortages of atabrine, penicillin, dental items, litters, blood, morphine, surgical instruments, and so on, this book outlines the many problems concerning the forecasting of needs, the acquisition of raw materials, the transportation from plants to depots to users, the problems of packaging and storage, all of which effected the adequacy of medical supplies during the last major conflict.

This document is a part of a historical series prepared by the Office of the Surgeon General, Department of the Army, recounting data concerning all of these factors. Included are specific sections covering primary difficulties as related to medical supply in the Zone of the Interior, European Axis, Japan, and the China-Burma-India Theater. The difficulty in logistical problems depending upon variations of terrain, climate, docking facilities, overland transportation, as well as geographical differences between the Pacific areas as contrasted to the European area, are all outlined.

Dr. Leonard D. Heaton, the present Surgeon General of the U.S. Army, sums up the entire problem in the Foreword of the book in the following statement:

"Imagine if you can the entire population of the city of New York suddenly dispersed around the world, dependent upon the U.S. Army for medical attention under every conceivable circumstance, and you will begin to comprehend the magnitude of the medical supply operation in World War II."

The book is valuable as a source document for persons involved in the logistics of rendering medical care.

O. Wexler

Basic Diagnostic Radiology. Malcolm D. Jones, M.D. St. Louis, 1969, Mosby. Pp. 266. Illustrations 511. ($11.75)

This book is oriented to students and is general in scope, with emphasis on those areas most frequently questioned by the students. Basically, it is a complete outline with an explanatory text on an amazing number of normal and pathologic entities, copiously illustrated with reproductions of average textbook quality. The necessarily limited scope of a book of this size is balanced by a list of important works on each subject, classed as *Required, Recommended,* and *Additional Reading.*

Each chapter begins with an outline that has good reference value, but is not highly readable. The author then wisely decides *not* to limit the text to the subject matter of, or the order of, the outline.

Didactic statements, while comforting to the beginner, often give information which must later be modified. This appears to be the case on page 58, where the following statement is made: "A single nodular density, without findings or a previous history of other systemic disease, particularly neoplasm, will most frequently be inflammatory in origin. "The author does not describe the character of the nodule so that one's mind veers to an image of a "coin" lesion, rendering the statement inaccurate. Similarly misleading statements are encountered elsewhere in the book.

One of the most complete chapters is that on the skull and facial areas. Technic is included in detail, though the descriptive text does not always agree with the diagrams, which are accurate (Page 216). No mention is made of the effect of technic on the appearance of the roentgenogram, nor has the reviewer found mention of tomography. The intricate anatomy of the facial and temporal regions is well demonstrated with the aid of diagrams and of films.

On the whole, the student may gain a general organized impression of the lights and shadows of the roentgen image if guided through its chapters with associated clinical material and personal instruction. In this reviewer's opinion the greatest deficit is that it deals with the roentgen image as an integral entity without correlation between it and the clinical and laboratory findings. This lack of correlation portends a failure to instill in the student the importance of understanding the inseparability of the various medical specialties. CARYE-BELLE HENLE, M.D.

Pulmonary Emphysema and Related Lung Diseases. Theodore Rodman, M.D. and F. H. Sterling, M.D. St. Louis 1969 Mosby. Pp. 468. Illustrations 294. ($27.50)

Here are the findings of an extensive investigation into obstructive lung disease. The authors have derived data from many sources, and then seasoned the material with their own findings.

Emphysema has become a major health problem that must be recognized by all practicing physicians. It is not important that we in the United States call it emphysema and the British call it chronic bronchitis. It is essential to recognize that chronic bronchitis and emphysema are two separate diseases. Each can occur alone with unrelated etiology or can co-exist. Etiologic factors may be common to both.

The chapters on treatment relate well the need for the medical practitioner to diagnosis and prescribed needed medications, oxygen, nebulization, and pulmonary physiotherapy. He must also practice supportive psychotherapy.

This excellent text will be of value to the student, the resident, and the practicing physician who has contact with people presenting pulmonary emphysema and its related diseases. The book is a pleasure to read, and will be referred to many times. The publisher, however, in an attempt to save paper used a small size type and a paper with excessive glare. This is the only defect in an otherwise valuable book.

WILBUR F. JEHL, M.D.

Studies in Clinical Enzymology. D. P. Mullan, M.D. St. Louis, 1969, Mosby. Pp. 238. Illustrated ($12.00)

This monograph will be of interest to research scientists engaged in clinical and basis research in enzymology. The eleven chapters cover the recent developments and applications of enzymology in: cardiac diseases, tropical disease, pregnancy, cervical carcinoma, diabetes mellitus, hypertension, urinary tract disease, abnormalities of cerebral spinal fluid, and certain inherited metabolic abnormalities. Contributing authors wrote four chapters. Of limited interest to physicians in the United States are such subjects as: African heart disease, tropical disease, and amebiasis. Enzymology of cervical cancer will be of wide interest but the studies described are inconclusive and not available as ordinary laboratory procedures. Cytologic examination remains the most reliable technic for the detection of benign and malignant diseases of the uterine cervix as well as uterine corpus.

The book is not organized for clinical practitioners. Each enzyme is discussed as an entity, listing conditions in which the level is elevated or diminished. The practicing physician would be more interested in diseases as entities in which the level of various enzymes are covered. The bibliographies are good and cite papers as recently as 1967.

ALLAN LAZAR, M.D.

The Role of Learning in Psychotherapy. Edited by Ruth Porter with contributions by 22 authorities. Boston, 1968, Little Brown. Pp 340. ($12)

Should the psychotherapist seek to modify the patient's maladaptative behavior, or is he expected to change his personality? The latter is the aim of the traditional "deep" psychotherapies which were developed in the middle of the nineteenth century. Somewhat newer are the "reconditioning" therapies which seek to alter behavior so that undesirable patterns are extinguished through the reinforcement of the desirable ones. This book is a transcript of a Ciba-sponsored symposium on the subject. Each of the fifteen primary papers is followed by a full and frank discussion so that, on the whole, this is a lively and thought-provoking volume.

Actually, of course, the two traditions are not that distinct. Even the most single-minded psychotherapist does aim at modifying behavior and the most convinced behaviorist has to concern himself with the emotional roots of the patient's symptoms. Many psychotics, especially paranoid ones, are impervious to demonstrations of the irrationality of their thinking, a fact which is not well dealt with in this symposium. On the whole, however, this is an excellent, in-depth view of the problem and the pediatrician, the psychiatrist, and the internist will find it a stimulating treatise. HENRY A. DAVIDSON, M.D.



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Indication—Oral contraceptian.

Contraindications—Thrambaphlebitis, thrombaembolic disorders, cerebral apaplexy or o past history of these conditions, markedly impaired liver functian, known or suspected carcinoma of the breast, knawn or suspected estrogen-dependent neaplasia, undiagnosed obnarmal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disarders (thrombaphlebitis, cerebravasculor disorders, pulmonary embolism, retinal thrambasis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking orol contraceptives. In these controlled retrospective studies, involving 36 reported deoths ond 58 hospitalizotions due to "idiopathic" thramboembolism, stotisticol evoluotion indicated that the differences observed between users ond non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Diseose in Users and Nan-Users af Oral Cantraceptives in Britain.

Categary	Mortality Rates		Haspitalization Rates (Marbidity)
	Age 20-34	Age 35-44	Age 20-44
Users af Oral Cantraceptives	1.5/100,000	3.9/100,000	47/100,000
Nan-Users	0.2/100,000	0.5/100,000	5/100,000

No comparoble studies ore yet avoilable in the United Stotes. The British doto, especiolly os they indicate the mognitude of the increased risk to the individual potient, connot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medicotion pending exominotion if there is sudden portial or complete loss of vision, or sudden onset of proptosis, diplopio or migraine. Withdrow medication if popilledemo or retinol vascular lesions ore found.

Since the sofety of Ovulen in pregnoncy hos not been demonstroted, it is recommended that pregnancy be ruled out for ony potient who hos missed two consecutive periods before continuing the contraceptive regimen. If the potient has not adhered to the prescribed schedule the possibility of pregnoncy should be considered ot the first missed period.

A smoll fraction of the hormone ogents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infont cannot be determined at this time.



Precautions—Pretreatment physical examination shauld include special reference ta the breasts and pelvic organs, and o Papanicolaou smear.

Endocrine ond passibly liver function tests may be affected by Ovulen. Therefore, it is recammended that such tests if abnormol be repeated after the drug has been withdrawn far two months.

Pre-existing uterine fibramyomas may increase in size under the influence af progestogen-estrogen preporations.

Because these ogents may cause some degree of fluid retention, conditians which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breokthrough bleeding, and oll irregular vaginal bleeding, consider nanfunctianal causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a histary of psychic depression and discantinue the drug if severe depressian recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, avarian, adrenal, hepatic or uterine functian owoits further study.

A decrease in glucase tolerance has occurred in a significant percentage of potients on oral contraceptives. The mechanism of this decreose is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseol clasure Ovulen should be used judiciausly in young patients in whom bone growth is not complete.

The age af the patient constitutes no absalute limiting factar, althaugh Ovulen therapy may mask the onset of the climacteric.

The pathologist should be infarmed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A stotistically significont assaciatian has been shawn between use of oral cantraceptives and the following seriaus odverse reactians: thrambaphlebitis, pulmonary embolism.

Although available evidence is suggestive of an assaciation, such o relotionship has been neither confirmed nar refuted far the following serious odverse reoctions: cerebrovosculor accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following odverse reoctions ore known to occur in potients receiving aral contraceptives: nouseo, vomiting, gostrointestinol symptoms (such os obdominol cromps ond blooting), breokthrough bleeding, spotting, change in menstruol flow, omenorrheo during ond ofter treotment, edema, chloasmo or melosma, breost changes (tenderness, enlorgement, secretion), chonge in weight, changes in cervicol erosion and cervical secretions, suppression of lactotion when given immediotely post portum, cholestotic joundice, migroine, allergic rosh, rise in blood pressure in susceptible individuols, mental depression.

Although the following odverse reoctions hove been reported in users of orol controceptives, on ossociotion hos been neither confirmed nor refuted: onovulotion post treotment, premenstruol-like syndrome, chonges in libido, chonges in oppetite, cystitis-like syndrome, heodoche, nervousness, dizziness, fotigue, bockoche, hirsutism, loss of scolp hoir, erythemo multiforme ond nodosum, hemorrhogic eruption, itching. The following loborotory results moy be oltered by orol controceptives: hepotic function: increosed sulfobromophtholein ond other tests; coogulotion tests: increose in prothrombin, Foctors VII, VIII, IX ond X; thyroid function: increose in PBI ond butonol extroctoble protein bound iodine, ond decreose in T^3 uptake volues; metyropone test; pregnanediol determinotion.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

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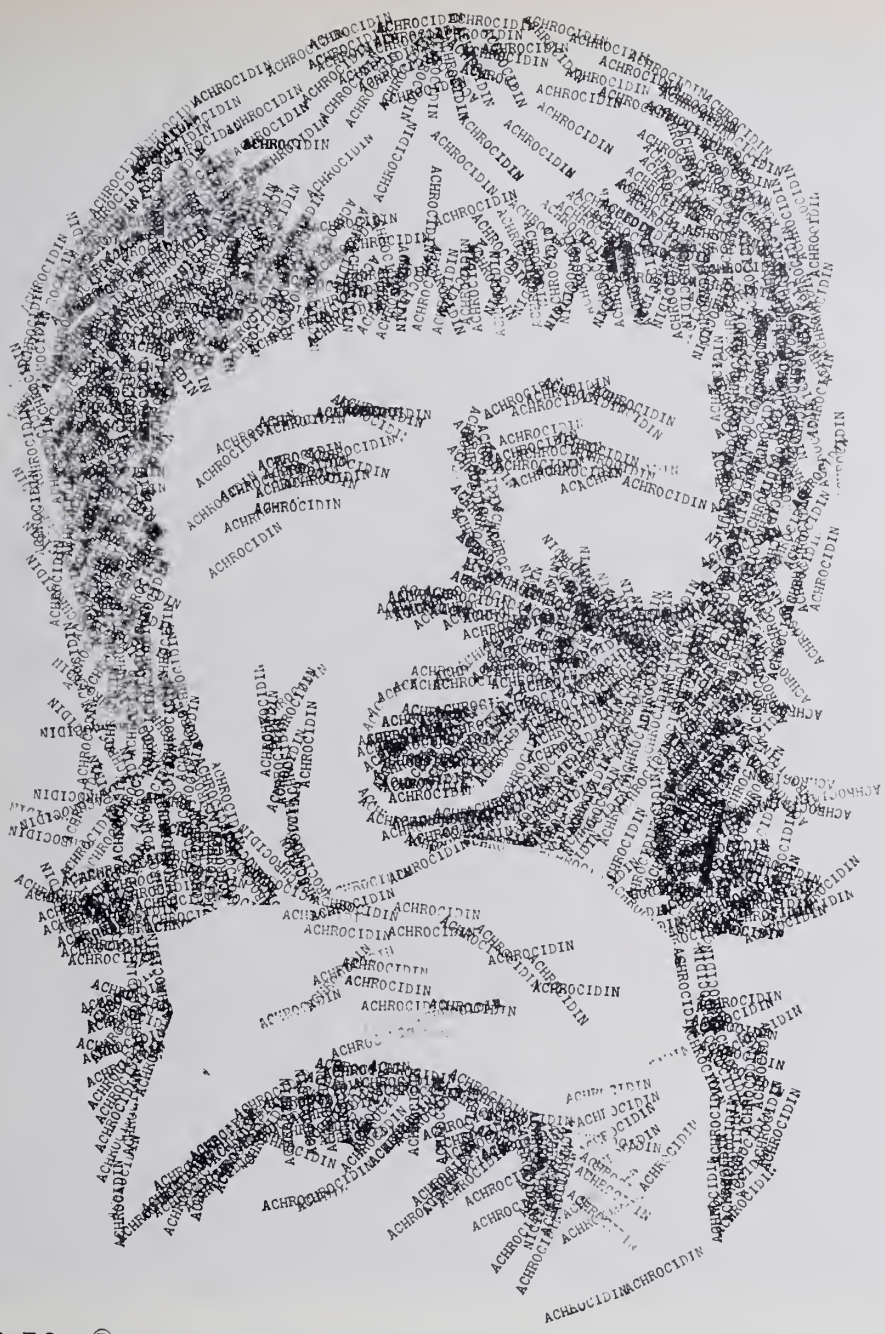
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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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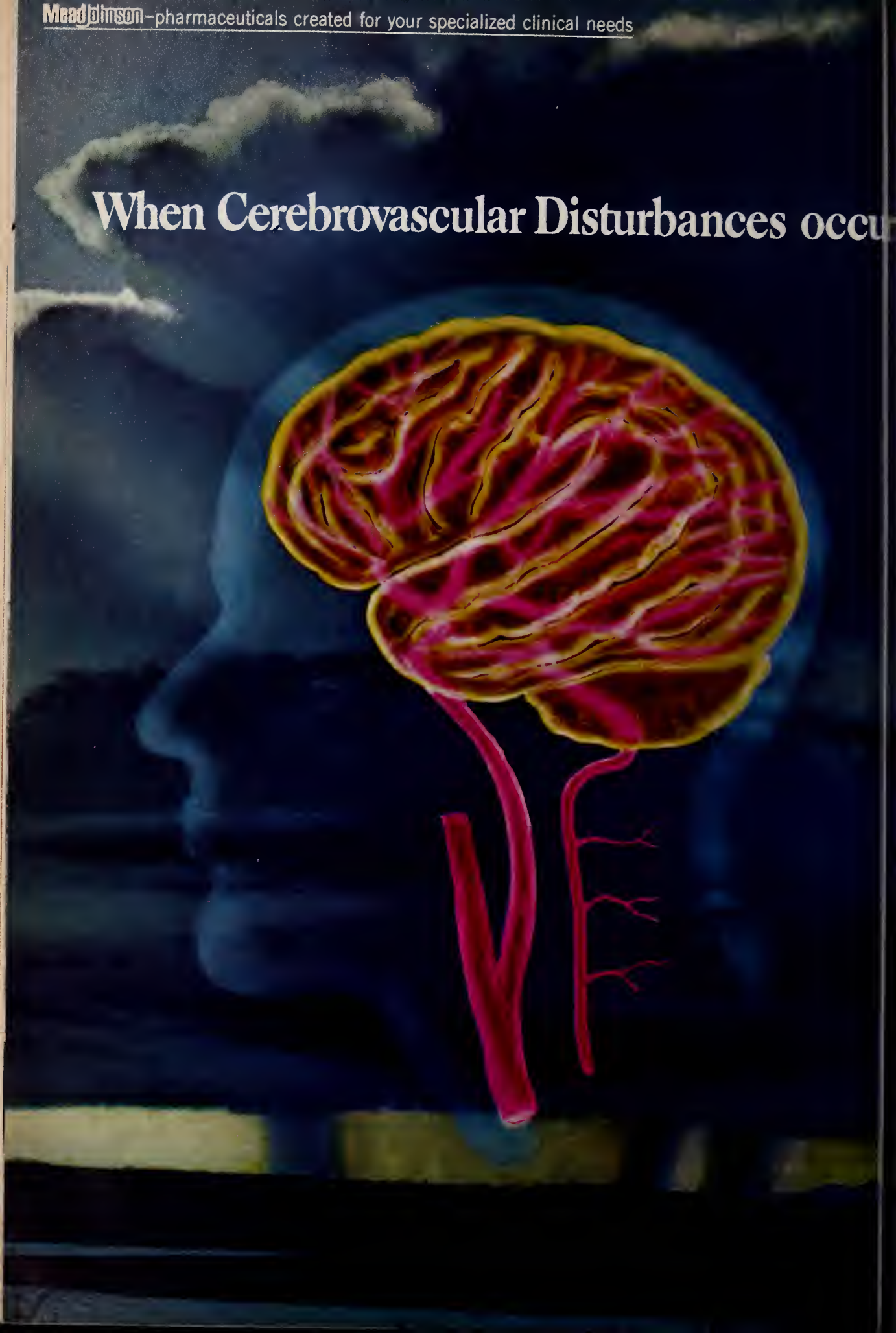
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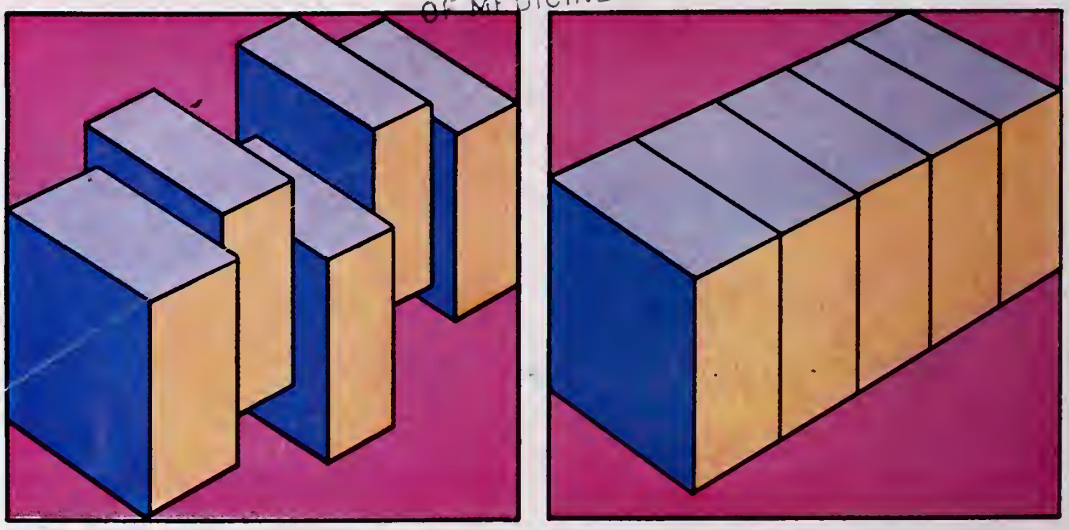
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CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
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PRECAUTIONS: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
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Accident: may be EXTENDED to Lifetime
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$1,000 a month maximum NEW LONG-TERM PLAN.
Payable up to Lifetime for accident — Age 65 for sickness
Choice of waiting periods:
Benefits may begin on 1st, 15th, 31st, 61st or 91st day.

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$10,000 to $100,000 of Convertible Term Life Insurance.
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$15,000 maximum for Covered Expenses as stated in the policy for each accident or sickness, covering member, spouse, and eligible children. $500 deductible, 20% co-insurance. (Physicians' and surgeons' fees are not a Covered Expense.)

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$200,000 maximum for member, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance.

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Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected or have applied for membership.

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75 MONTGOMERY STREET JERSEY CITY, NEW JERSEY 07302
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Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

HE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF MATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

JTREXIN, the non-steroid "uterine ing factor" has been found to be useful nany clinicians in controlling abnormal ne activity.

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- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
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(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

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He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

How do you score in history?

What a patient tells you about himself is often more important than a battery of routinized laboratory tests and procedures. Most medical authorities agree tests are best used to substantiate a medical history (not substitute for it).

Another factor often overlooked is the role a well-planned interview can play in establishing a warm doctor/patient relationship. And, after all, most doctors (New Jersey ones included) agree that's what private medicine is all about.

Blue Shield shares your feeling for private medicine. Also your commitment to make it work.

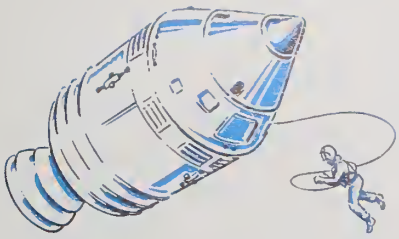
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Fight waste.
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Man in space, now fait accampli, re-emphasizes the impartance af Ura-Phosphate therapy. Research inta the effect af space travel an the astronaut reveals that weightlessness causes lass af bone calcium. As the bones are required ta bear less and less af the weight af the bady they lose calcium, increasing the calcium cantent af the urine. When physical activity is reduced, the acidity af the urine shauld be adjusted ta keep increased calcium in salutian . . . . a prophylaxis ta prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For pratectian of the inactive patient 1 ar 2 tablets every 4 ta 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets an retiring will keep residual urine acid and sterile, cantributing ta camfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

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Manufacturers of Ethical Pharmaceuticals

The AMBAR® SCRAPBOOK of

Obesity Oddities

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CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

for the vitamin deficiency that diet alone doesn't satisfy...

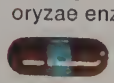


Thera-Combex H-P®

This high-potency vitamin C and B-complex combination starts where diet stops

Kapseals®

Each Kapseal contains: ascorbic acid, 500 mg.; thiamine mononitrate, 25 mg.; riboflavin, 15 mg.; pyridoxine hydrochloride, 10 mg.; cyanocobalamin, 5 mcg.; niacinamide, 100 mg.; *dl*-panthenol, 20 mg.; Taka-Diastase® (Aspergillus oryzae enzymes), 2½ gr.



The Brown capsule with Green band is a Parke-Davis trademark.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS



Benylin®
EXPECTORANT

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride), Parke-Davis; 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.
An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT *is the leading cough preparation of its kind.* BENYLIN EXPECTORANT *tends to inhibit cough reflex ...soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes* BENYLIN EXPECTORANT *easy to take.*
PRECAUTIONS: *Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with* BENYLIN EXPECTORANT *should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing* BENYLIN EXPECTORANT.
ADVERSE REACTIONS: *Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.*
PACKAGING: *Bottles of 4 oz., 16 oz., and 1 gal.*
Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

50669

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported, in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium and BUN during therapy, particularly in patients with suspected or confirmed renal or hepatic insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—their combined use can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk; thus adverse reactions which have occurred in adults may occur in the fetus or newborn infant. Rarely, thrombocytopenia or pancreatitis has developed in newborn infants whose mothers had received thiazides during pregnancy. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte determinations. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Adjust dose of antihypertensive agents given concomitantly.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, altered carbohydrate metabolism, hyperbilirubinemia, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

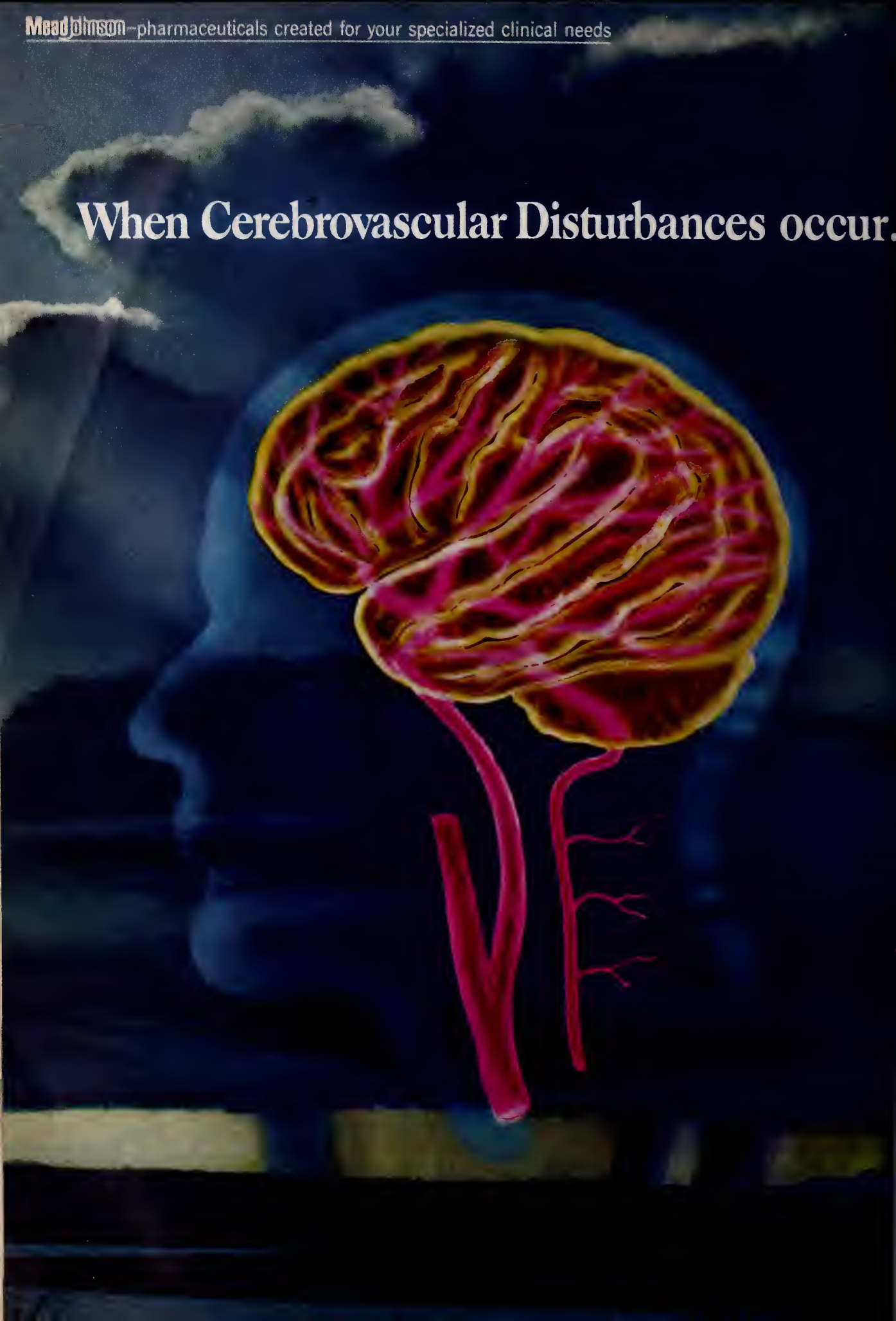
Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories

Mead Johnson—pharmaceuticals created for your specialized clinical needs

When Cerebrovascular Disturbances occur.



...with episodes of vertigo, headache, confusion, sensory loss, slurred speech, consider

VASODĪLAN®

(ISOXSUPRINE HCl)

to help relieve symptoms by preventing vasospasm and increasing cerebral blood flow

Mead Johnson
LABORATORIES

Although not all clinicians agree on the value of vasodilators in vascular disease,[1] several investigators[2-5] have reported favorably on the effects of isoxsuprine on cerebral blood flow. Effects have been demonstrated both by objective measurement[2,5] and observation of clinical improvement.[2-4]
Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODĪLAN tablets, isoxsuprine hydrochloride 10 mg. **Dosage:** Oral—10 to 20 mg. (1 or 2 tablets) t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories **References:** (1) Fazekas, J. F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: Angiology *15*:No. 2 (Feb.) 1964. (2) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960 (4) Dhrymiotis, A. D., and Whittier, J. R.: Current Therapeutic Research *4*:124-128 (April) 1962 (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964

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71169

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A. H. Robins Company, Richmond, Va. 23220 A·H·ROBINS



Owner Breaks Arm When Yacht Runs Agroun

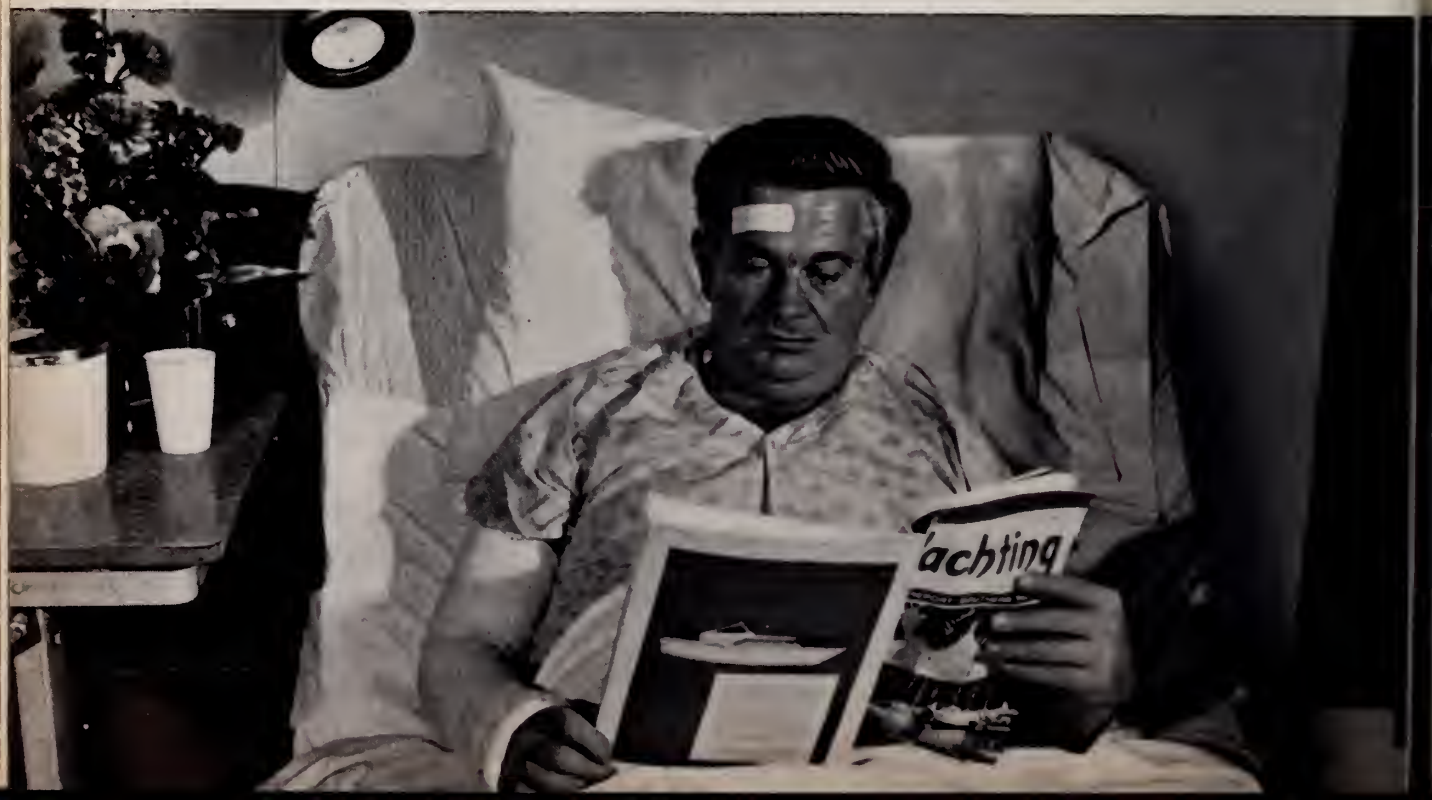
Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm ... tially capsized. The fire depart had to rescue Waters by small ... Damage to the yacht is estimat

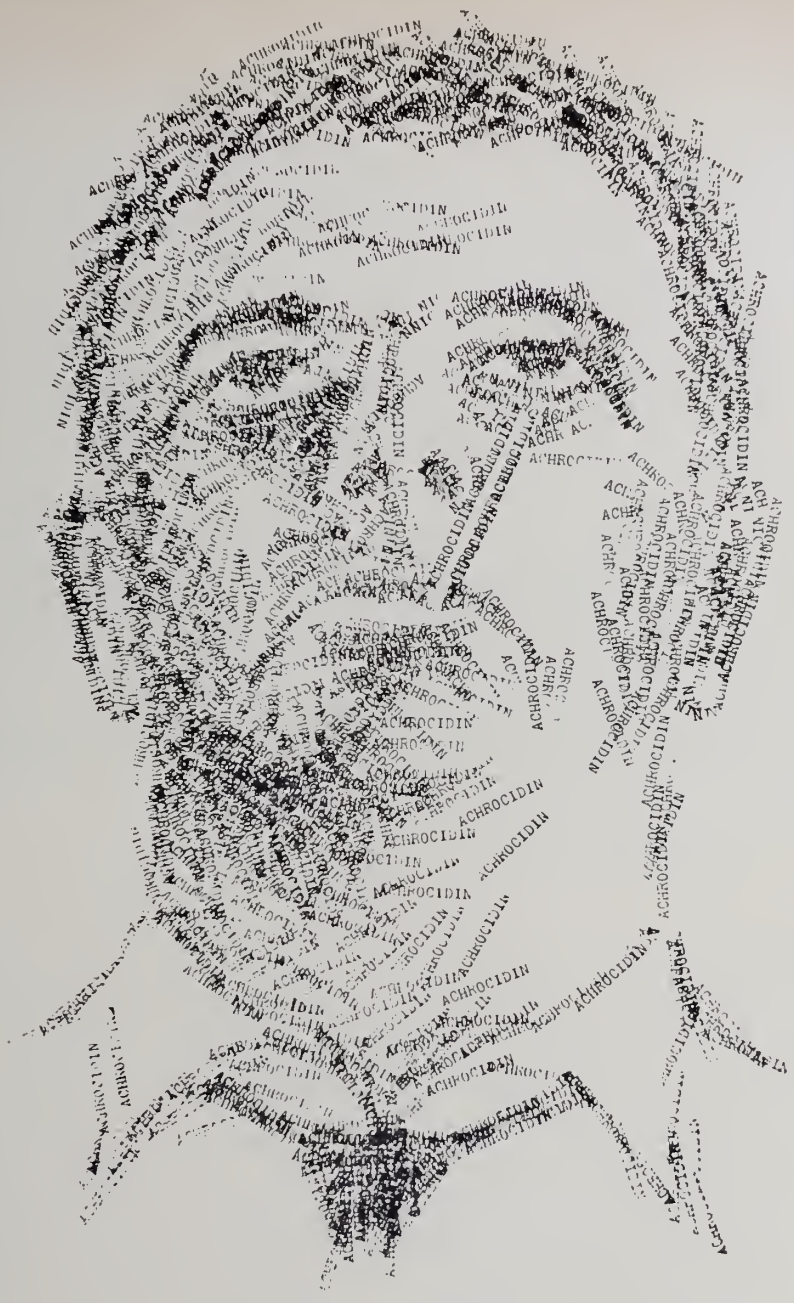
Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. Contraindications: Hypersensitivity to any of the components. Precautions: As with all phenacetin-containing products excessive or prolonged use should be avoided. Side effects: Side effects are uncommon, although nausea, constipation and drowsiness may occur. Dosage: Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.





Achrocidin® Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

535-9

Mead Johnson–pharmaceuticals created for your specialized clinical needs

when your patients need continuous potassium supplementation...



they need the proved effectiveness and safety of

K-LYTE®

Each effervescent tablet supplies: 2.5 Gm. potassium bicarbonate (25 mEq. elemental potassium), 2.1 Gm. citric acid, cyclamic acid

Three clinical studies* confirm the effectiveness of good tasting K-Lyte as a source of supplemental potassium to increase low levels of serum potassium and to maintain normal levels. Patients were on continuous diuretic therapy and salt-restricted diets. K-Lyte dosage was one tablet b.i.d.

Serum Potassium Levels (in mEq./L)

Number of patients	Mean initial value	Mean final value
14	3.23	4.83
16	3.50	4.40
25	4.52	4.47

K-Lyte can offer effective potassium supplementation without the gastrointestinal complications sometimes associated with potassium chloride tablets and thiazide-potassium chloride combination therapy. Effervescent K-Lyte is taken in solution, speeding up absorption to avoid these hazards.

Composition: Each tablet contains potassium bicarbonate (2.5 Gm.), citric acid (2.1 Gm.), cyclamic acid, artificial flavor and color.
Contraindications: When renal function is impaired, or if the patient has Addison's disease, potassium supplementation should not ordinarily be instituted.
Precautions: Should not be used in patients with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations.
Side Effects: While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum.
Administration and Dosage: K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement.
How Supplied: Effervescent tablets—boxes of 30 and 250 (orange or lime).

*Reports on file: Medical Research Department, Mead Johnson Laboratories, Evansville, Indiana 47721

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Mead Johnson
LABORATORIES



Because patients can't, or won't, exercise muscles and joints while the pain persists

Encourage massage Encourage exercise

"As a surface analgesic it [GER-O-FOAM] enhances the usefulness of massage by reducing pain, thus permitting functional exercises otherwise impossible to administer."[1]

In rheumatoid and osteoarthritis, low back pain, painful healed fractures, whiplash and frozen shoulder, GER-O-FOAM . . .

- provides fast penetration of skin by anesthetic and analgesic ingredients for prolonged relief.
- facilitates exercising and increases range of motion.

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1. Gordon, E.E. and Haas, A., Industr. Med. Surg. 28:217, May, 1959.

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REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32,1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

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EDITORIALS

Rising Malpractice Insurance

Not all states have professional liability coverage with carriers who cooperate with the medical societies. In that sense, New Jersey is, perhaps, especially fortunate. This, for example, is from the July 1969 *Arizona Medicine:*

In Michigan, an appellate tribunal reversed a lower court which prohibited the plaintiff from using the defendant doctor as an expert witness *against* himself. The court said that, "a civil defendant has no protection against subjecting himself to liability. If his testimony will provide facts which will aid the court in arriving at a just decision, he has the duty to testify. Any loss to the sporting aspect of the adversary proceedings would be outweighed by the benefit to the judicial system." The courts therefore make quite a distinction between a murderer or rapist and a physician on trial for malpractice. The criminal is prohibited from testifying against himself.

The time-worn and flimsy excuse for liberalizing rules of evidence and new methods for proving malpractice is the "conspiracy of silence." This seems to mean that if a physician reviews the evidence and doesn't find a departure from the standard of care and cannot therefore testify that malpractice existed, he is a "conspirator" against the patient who is praying for an award. It simply is not true that every law suit against a doctor resulted from malpractice. If a physician has done nothing wrong, why should the plaintiff's attorneys become so irate because other physicians refuse to testify that he has?

There has been no dearth of suits against doctors in recent years, and every case has produced physicians who testified in behalf of the plaintiff. Where is the conspiracy of silence?

In the past, the plaintiff had to establish that the physician departed from the standard of practice in the community in which the doctor practiced. The theory now is that because of modern transportation, communication, text books, T.V. medical education, graduate courses, medical literature and meetings, even the "similar community" ruling is a thing of the past. A small community without a resident radiologist, a pathologist who visits twice a week, no intensive care unit, no anesthesiologist, (perhaps a colleague who does the best he can in anesthesia in emergencies), no coronary care unit, no respiratory care unit, no interns or residents, no facilities for blood gases, no cardiologist, internist, pediatrician, allergist and so on, certainly does not give the small town doctor the same resources or ability to handle difficult and serious cases. It isn't the "wives" who are driving the doctors out of the small towns. It is the courts who hold the county practitioner now to the same standard of excellence as the physicians in the large centers with unlimited consultive and other facilities.

Many professional liability carriers have withdrawn from the malpractice field. Some insurance companies will not write policies covering physicians who do operative procedures.

A doctor makes thousands of life and death decisions in his professional lifetime, yet if he makes one wrong decision, he may lose all he has worked a lifetime to acquire plus his professional reputation, and be unable to obtain liability insurance thereafter. Many excellent surgical assistants are not helping on cases they do not originate because this puts them in the category four classification of a surgical specialist with current premiums of $1280 per year, and no end to the premium rise in sight.

Some physicians who have had claims against them are rated up to above $1000 a year in premiums, and you are familiar with the mass cancellations of malpractice policies in Utah and Alaska.

The high cost of medical care is greatly contributed to by the need for the physician to

protect himself. It is questionable whether this makes for a higher standard of practice.

In Canada and Britain it is both unethical and illegal for a lawyer to accept a case on a contingency basis, and they have very few "nuisance" suits.

Will the day come when a doctor will be forced to say, "I'd like to help you, but I just can't take the risk!" Where will it all end?

Curing And Caring

As the curable diseases are brought under control, the "incurable" ones loom larger and larger in our practices. At this point, the doctor's mission shifts from cure to care. Etymologically the words are identical: both stem from the Latin *cure,* care. But that single vowel — that shift from the *u* of "cure" to the *a* of "care" makes a world of difference to too many doctors. The physician can do much to make comfortable the patient with chronic, nontreatable illness. But many of us are embarrassed in the presence of such a patient. He is a living repudiation of our mission — or so we think. We would like to transfer responsibility to the family, to the visiting nurse, to a social agency, to a home for the chronically ill — anything to get the untreatable patient off our own active list.

But there is still need for compassion and for care. There are still technics for relieving pain and disability. There is still the cheer of solace. And there is always that last blessing in Pandora's box: hope. There are patients who have outlived the doctors who have pronounced death sentences.

To care for patients we have to care for people. The word "care" here has a double meaning. In the first clause it meant "manage" in the second clause it meant "like people — or feel comfortable with them." But this is no idle pun, it is the stuff of healing art. Every medical student is told: treat patients not diseases; treat sick people not pathologic lesions. The advice is well meant but is often meaningless until it springs into action. Anybody can handle a self-limiting disease. But it takes a real doctor to keep burning the spark of hope and to keep comfortable the patient with permanent illness. Let us be worthy of that challenge.

The Great Epidemic: 150 Deaths A Day!

They joke about "the ugly Americans." Well, 1968 was an ugly year for Americans (and it appears that 1969 was not much better). Tragedy of spectacular magnitude became a frequent front page occurrence. But a quieter national calamity took its dreadful toll on all the days before, during, and after the offensive in Vietnam, the riots, the killings.

It was "quiet" only because it was not concentrated in a single place at a single time. There was no focus to put this misery on the front pages. To the families and friends of 55,300 men, women, and children killed in auto accidents, however, it was the ultimate calamity. To the 4,400,000 victims of injury, it was hard core agony. The economic loss, about 13.5 billion dollars, was an appalling waste.

This view of 1968 is contained in the annual booklet of highway accident statistics from The Travelers Insurance Companies. Here we learn that the 1968 highway toll followed a year that saw a leveling off in the number of highway deaths and injuries. In 1967 approximately 53,000 lives were lost in motor vehicle mishaps — 4,200,000 persons were injured.

Why the increase? Was it because Americans were lulled by the "improvement" of the preceding year? Or lulled by the joy of speed, or the nice, new, smooth highways. Whatever the reasons more than 55,000 people were killed in automobile accidents that year. And who is in the business of preventing diseases and accidents?

We are.

If the doctor will take seriously his duties as a school team or sports physician, he will find that there is more to this work than using a stethoscope.

Pre-Adolescent Athletics

The Role Of The Parents, The Family Physician And The Team Sponsor

Samuel C. Southard, M.D./Ventnor City

Physical exercise and participation in athletic activities should be an important part in the life of every healthy child. Swimming and running are especially recommended for the pre-adolescent child. These two sports increase stamina, cardiac, and pulmonary reserve. They are not dependent on large muscle mass unobtainable prior to the gonadal stimulation which occurs in adolescence.

Violent body contact sports are *not* recommended for this age group since they require muscle mass for protection and performance. The two sports especially dangerous at this age are tackle football and boxing.

Too many parents accept, encourage, and actively promote body collision sports at this age level.

For every child who is a candidate for organized competitive sports, there are three spheres of responsibility which should be operative: the *family's* responsibility, the *physician's* responsibility and the responsibility of the *organization* sponsoring or supervising the sport. These should be overlapping and the physician should be cognizant of all three spheres.

Family Responsibility

The parents should be the persons to determine if the sport activity contemplated is geared to the level of the physical, emotional, and mental maturity of their child. Frequently, they need guidance in this and it is best supplied by the child's physician, whose opinion should be respected and accepted. The fact that the child's age contemporaries are participating in this sport should not be sufficient justification alone to allow the participation of their child. Where the child is an acceptable candidate, he should participate with co-equals in mental and physical development.

The parents must examine their child's day and week to see that he has adequate time to indulge in all of the activities that he or they wish or require. It is possible that a child who is playing organized competitive sports, taking music lessons, participating in Cub Scouts and attending church or taking religious instructions regularly, may be too tired, or too busy, adequately to prepare or understand his schoolwork. The parents should guard against having their child caught up in a hectic whirlwind which will interfere with his efficiency and development. The parents should provide for adequate diet, rest, and study time. They, too, are in the best position to detect the onset of any acute condition which would temporarily prevent participation.

Finally, the family or the head of the family, in addition to assuming his own responsibility should ascertain that the physician and the sponsor do assume their individual responsibilities. All too often, the young gladiator is sent to the arena with no more than a hurried but fond pat on the head and no effort is made to investigate the other spheres. It is the family's responsibility to see that the child has a medical evaluation for the sport contemplated and to investigate the facilities offered for their child's participation. The

parents should also respect the requirements of the coach relative to diet, proper rest, and avoidance of bad habits.

The physician should be aware of the family's responsibility to their child regarding competitive athletics and he should prod their interest and participation where necessary.

The Physician's Responsibility

Every child who is a candidate for competitive sports should have recorded a complete history and a meticulous examination yearly or pre-seasonly. The physician should evaluate the suitability of the candidate for the specific sport and counsel the parents as to their child's participation. Where indicated by medical judgment, the child should be prohibited from sports detrimental to his health. The physician's opinion should be absolute. Many sports tragedies are due to previously unrecognized health problems.

The following is a suggested format for the pre-seasonal or annual medical evaluation. The headings for the visit are listed on the left-hand side of the page and a few provocative and pertinent questions directed to the physician are noted on the right-hand side of the page.

Administrative Data	
Name Address Grade Father's name Place of business Phone number Name of family physician and dentist Date School Date of birth	This child may be hurt and your office might be called since the team coach may not be able to find anybody at the child's home. Hence, have complete information on this child, so as to make proper disposition of the call.
History	
Chief complaint and the history of the complaint	Or in its absence, any complaint?
Past Personal History	
Gestation; diseases during gestation, nutrition, general state of mother's health	Any inkling of a congenital anomaly previously undiagnosed?
Delivery Immediate neonatal history	Any inkling of previously unsuspected or undiagnosed brain damage? Coordination?
Infancy—Motor and mental development and nutrition	Any suggestion of motor retardation? Etiology?
Early childhood development—Entrance into school	
Past Illnesses Common contagious exanthemata Rheumatic fever Pertussis Asthma, allergies Other illnesses —	Severe? Encephalitis?
Past operations	Any relation to the proposed physical activities? Hernia?
	Cardiovascular surgery? Neurologic surgery? Orthopedic surgery? Previous removal of one of paired organs? How does this affect applicant's status?
Serious accidents	Head trauma? Fractures? Recovery? Joint damage? Previous organ trauma?
Immunizations Type Date	Proper basic series? Boosters up to date?
Family history Mother Father Siblings Grandparents	Blood dyscrasia? Tuberculosis? Diabetes? Bleeding disorders? Hypertension? Any clue to indicate further studies prior to certification as fit for sport?
Systemic Review	
Cardiovascular system	Fainting spells? dyspnea? claudication? phlebitis?
Pulmonary system	Dyspnea? cough? hemoptysis?
Neurologic system	Fainting or blackout spells? headache? convulsions?
Orthopedic system	Joints?
Skin	Fungus infections? Furunculosis? Impetigo?
	Locker room problems?
EENT	Hoarseness? Blurred vision? Pain in eyes?
Genito-urinary system	Enuresis? Dysuria? Undiagnosed hydronephrosis is a frequent cause of rupture of kidney.
G.I. system	Melena?

Physical Examination	
General appearance and body habitus	A child with long thin neck and prominent thyroid cartilage is a candidate for neck injuries in football.
Weight Height	
Extremities	
Posture	Observe gait.
Heart	Murmur? Is it significant or innocent?
Blood pressure	Coarctation?
Femoral pulsations	Aortic stenosis?
Lungs	
Chest	
Abdomen	Splenomegaly, recent mononucleosis?
Genitalia	Should child with one testicle play contact sports? Should a child missing one of any paired organ play contact sports?
Skin	Pustular lesions? Significance to sport anticipated? (Wrestling)
Scalp	
Eyes including vision with and without glasses	Should contact lenses be permitted in body contact sports? Shatterproof lenses.
Ears and hearing	
Mouth	
Dental status	Removable bridges? Loose caps?
Tongue	
Tonsils	
Nose	
Neck, thymus, thyroid	
Lymph glands	
Nervous system coordination, reflexes, sensory apparatus, and cranial nerves	
Emotional problems	Recognized?
Laboratory Data	
A complete urinalysis, intradermal tuberculin and blood count are recommended.	"Minor" abnormalities should be investigated before certification for sport.
Other laboratory tests and X-rays as indicated.	
Pre-Game Inspection	
	Recent illness, current illness, respiratory infection, pustular lesions?

Following this examination and the laboratory tests, the physician should make specific written recommendations to the family and/or the sponsoring body in reference to his patient's suitability for competition in sports. The physician should retain a copy for his files.

Sponsor's Responsibility

The following are the sponsor's prime obligations or responsibilities:

1. The first responsibility of the sponsor is to determine whether the family has completed their responsibilities to the child.

2. The sponsor should require a preseasonal medical evaluation by the child's physician and should await a written report from the physician before allowing the child to engage in practice sessions. When the child does not have a private physician, he should be referred to an established clinic; or the sponsor should provide a physician to evaluate the child. This visit should be attended by one or both parents. It must include a complete history and a meticulous physical examination, using the format provided above.

3. The sponsor should provide continuous medical supervision during the season including medical attendance at games and equipment needed for emergencies. This supervision by a physician should include continuing consideration of the child's health, nutrition, physical condition, and special considerations pertinent to the sport, such as dental protective devices in football and voiding before games. The physician should evaluate previously injured players before letting them return to competition or practice. If the team physician is not the child's doctor, then he should require written reports and permission from that physician before allowing a previously injured athlete to return to competition. Even then, he should evaluate the child in light of his special knowledge of the sport and the child's past performance.

During competition in collision sports, there should be constant attendance by a physician. He should have at his disposal reasonable equipment to treat minor injuries and adequate transportation to remove more serious injuries to a hospital ready and equipped to handle such cases.

4. The sponsor should require adequate conditioning of the entire squad prior to beginning practice for the season. Practice should continue for a minimum of three weeks be-

fore the first game. This prevents injury by hardening the body and increasing stamina.

General principles of conditioning are as follows:

(a) Development of endurance depends primarily on the capacity of the cardiovascular and respiratory systems to function at full efficiency. Basically, this is a function of oxygen consumption. Long distance running, interval training, speed-play, and circuit training are integral parts. Interval training uses short distance running with short intervals of rest. Speed-play consists of jogging with short bursts of speed and circuit training consists of exercises, stunts, and weight training carried out on a time schedule.

(b) Development of speed of movement and reaction. Short sprints aid this. Reaction time can be speeded by practicing the characteristic movements of the sport and trying to do them as rapidly as possible.

(c) Development of appropriate flexibility. This is attained by calisthenics to help develop and maintain full range of motion of the joints. Exercise between seasons should include activities similar to the sport with special attention to strengthening those muscles especially needed in the sport. For instance, between baseball seasons, the boy should throw a ball, swing a bar or bat and strengthen the forearm muscles. He should avoid exercises that stretch the collateral ligaments of the knees, such as deep knee bends and duck waddling.

(d) Develop weight control. Crash diets should be strictly avoided. Also, attempts to lose weight before weighing in should be avoided.

(e) Development of body strength. This is best done through regular repetition of submaximal lifts. In baseball and basketball, fine muscle strength is important in protecting the knee joint. These exercises should be reserved for the late teen years and banned for pre-adolescent children.

(f) Adaptations to climatic conditions. This includes consideration of heat exhaustion, heat stroke, and salt depletion. Water should not be restricted.

(g) Physical rehabilitation from any previous injury.

(h) Continual practice of the specific skills needed in the sport. Thus, the hockey player should skate between seasons.

(i) Development of confidence. This is emotional conditioning. The player should believe his team, his coach, his teammates, and his own position are not only good but important.

(j) Development of good habits of general hygiene. Diet, rest, cleanliness, and avoidance of bad habits such as smoking, etc.

5. The sponsor should provide and require the use of proper equipment and protective devices as required by the various activities.

6. The sponsor should provide and maintain proper playing, practice, and sanitary facilities. Gymnasia should provide:

a. Playing space free of pillars or low overhanging fixtures and devoid of objects projecting from the wall less than eight to ten feet above the floor.

b. Screened or recessed drinking fountains, radiators, and windows.

c. Sidelines and backlines of the court sufficiently removed from the walls to prevent a player from colliding with the wall or with obstacles near the lines.

d. A floor that is resilient and is cleared of objects that might trip a player.

e. Sufficient space between the sidelines and the bleachers to prevent collision with them by a player.

f. Doors that open away from the playing area (no swinging doors).

g. Sufficient space for peak loads.

h. Arrangement to permit central supervision of the entire playing area.

i. Adequate exits in case of fire or emergency.

Shower rooms should provide:

a. Proper drainage, temperature, and vapor regulation.

b. Nonskid floors.

c. Liquid soap to prevent slipping on bars of soap.

d. Showerheads controlled by simple hot and cold water regulating systems located away from the water flow and an auxiliary central control to be used when a large number are showering simultaneously.

e. Slip-free drainage surfaces without stepover ridges or ledges.

Locker rooms should provide:

a. General sanitation.

b. A central office view of all showers and lockers.

c. No steps, ridges, or floor objects.

d. No swinging doors.

e. Adequate space for peak loads such as a change of class.

f. Careful planning of locker location to prevent crowding.

g. Screening of all fans.

Passageways between the locker room and gym should be provided with:

a. A safety tread and good lighting.

b. No swinging doors.

c. An entrance to the gym from the locker room separate from the locker room exit.

Facility maintenance should include monthly inspection of permanent facilities:

a. In the gymnasium: flooring, window screening, radiators, lights, and all other permanent equipment such as backstops, beams, and bleachers.

b. In the locker room: the condition of the lockers, floors, and benches.

c. In the shower areas: condition of drains, floors, showerheads, and footwalks.

d. In the stairways and passageways: condition of lights, flooring, and doorways.

Daily inspection should take note of the following:

1. The personal equipment of the players for cleanliness, tears, pins, and lack of support.

2. The showers for condition of the floors, drains, and showerheads.

3. The locker rooms to check general safety conditions and to close locker doors left open which is a common cause of injury when incoming groups dash into the locker room.

Playing fields should provide:

a. Adequate fencing from streets and highways.

b. Even, unbroken turf or sand without potholes, stumps, litter or other dangers to falling or sliding.

c. Baselines and yardlines should be painted with commercial chalk and not with hydrated lime or quick lime which may cause serious eye injury.

d. Spectator seating sufficiently back from playing area to avoid crash injuries.

e. Regular maintenance and inspection of grounds, especially pre-game inspection.

7. The sponsor should provide careful coaching. The Committee on the Medical Aspect of Sports of the American Medical Association lists this as leading to skillful performance which lowers the incidence of injuries. The coach should do the following:

a. Emphasize safety in teaching technics and elements of play.

b. Analyze injuries to determine causes and develop preventive measures.

c. Ban tactics which increase hazards and thus the incidence of injuries.

d. Plan practice periods and limit their duration.

The coach should promptly report injuries or suspected acute conditions to the team physician and request his decision as to therapy and fitness for further play.

The coach should be knowledgeable in his field and should keep abreast with developments in the sport by attending coaching clinics, symposiums, etc.

The coach should have as his goal the inculcation of high ideals and clean sportsmanship into his players, the citizens of tomorrow.

8. The sponsor should provide and require supervision of proper officiating. Good officiating lessens injuries and increases enjoyment of the game. Improper officiating is a major cause of sport injuries. One survey incriminated improper and inadequate officiating in 45 per cent of all accidents in high school sports. Good officials are just as concerned with creating good citizens and safety in sports as they are with adherence to the rules of the game. A good referee will stop a game if a child's chin strap is loose or broken. He will not allow teeth guards to be spit out, nor will he allow profanity or vulgarity.

Qualified and good officials are in demand; hence, the sponsor should be willing to pay for their services and not accept lesser officiating because it is free.

Officials should be sure that coaches and players are aware of the rules and they should enforce adherence to them.

9. The sponsor should provide adequate funds so that this responsibility can be assumed without equivocation or evasion.

10. Finally, the sponsor must accept and promote as his primary objectives the attainment of clean sports, clean living, and good citizenship.

Summary

The *parents* should make decisions regarding their child's leisure, time expenditure, mental and physical capabilities, and goals.

The *physician* should take a careful history and perform an in-depth physical examination and order whatever ancillary tests and procedures he deems necessary. He should relate his knowledge of growth, development, physiology, and anatomy with the sports contemplated and apply this to the child in question.

The *team sponsor* should be expert in the chosen sport. He should be adequately funded and organized to deliver the proper accouterments to the pre-adolescent athlete.

Finally, the parents must make the ultimate decisions and their family doctor should be part of this experience.

The author expresses appreciation to the Committee on Accident Prevention of the American Academy of Pediatrics for their suggestions during the preparation of this paper.

7217 Atlantic Avenue

AMA's Drug Advertising Policy

Speaking recently before a U.S. Senate Committee, O. L. Simenstad, M.D., explained that the "advertising policies of the AMA have consistently recognized the uniqueness of drug advertising in that it should not be directed to the public, but to physicians. Because of the public interests involved, it should be responsibly presented. As the drug products in this country have become more sophisticated, the Association's advertising policies have undergone evolution. Initially, an ethical manufacturer was required to disclose the formula of his advertised products. Today honest presentation of claims is the primary criterion.

"The policy of the AMA has been to update the advertising standards as the drug field changes. Two of the basic tenets have remained unchanged, however. One is that the appearance of advertising in AMA publications is *not* an AMA guarantee or endorsement of the product or the claims made for the product by the manufacturer; the other is that advertising space will *not* be sold unless the inclusion of advertising material does not interfere with the purpose of the publication."

Medicolegal Symposium Proceedings

The AMA now has available the printed proceedings of the 1969 National Medicolegal Symposium, which was sponsored jointly last spring by the Association and the American Bar Association. This large report includes the remarks of outstanding legal and medical authorities who participated in the three day meeting. Among the panel subjects are "Who Wants to Pay Unnecessary Taxes?" (estate planning, professional corporations); "Disability—What Kind and How Much?" (workmen's compensation, civil litigation, "doctor in the middle"); "Life, Death, and Human Transplantation" ("don't tie the hands of the medical innovator," "the patient must always come first," today's law and its problems); "How to Avoid Malpractice Liability" (why some MDs lose, danger zones in accident prevention, and "can legislative remedies help minimize claims?"); and "Medicolegal Vignettes" ("getting away with murder" and pretrial screening of malpractice claims).

Copies of the proceedings are available at $7 each from the AMA Order Department, 535 North Dearborn Street, Chicago. Orders sent on medical society letterhead are accorded 50 per cent discount.

A little understood, but increasingly important form of malignancy is here reviewed

Diffusely Infiltrative Carcinoma

A Biologic Entity

Sylvan E. Moolten, M.D./New Brunswick

In 1936 Jarcho developed an interesting correlation between certain types of carcinoma in regard to their manner of growth and the type and distribution of metastases. He proposed the term "diffusely infiltrative carcinoma" (in preference to such terms as lymphangitic carcinomatosis) in order to emphasize the features of this syndrome. Pathologists have long known of this condition, but most of their attention has been centered on the cytologic features of cancer (nuclear hyperchromatism, mitotic activity, bizarre cell and nuclear contours, loss of differentiation) and have failed to emphasize sufficiently the spreading tendency of cancer and the need to evaluate this feature in every cancer diagnosis.

The principal features of diffusely infiltrative carcinoma are its rapid growth, its interstitial pathways of spread, the insignificant size of the primary focus, the absence of nodule formation, and its histologic picture. In the typical case, the pre-existing tissues are spread apart by the tumor infiltration so that the original architecture is largely undisturbed. The tumor cells not only lack the capacity to adhere to other tumor cells to form well-defined units of structure, but often are poorly formed and rather primitive. In some cases the tumor cells are distended with mucus vacuoles resulting in "signet ring cell" cancer. The amount of stroma varies greatly in these tumors. In some cases there is diffuse permeation of tumor cells in tissue spaces and the stromal reaction is scanty. In other cases the stromal reaction is more abundant, often striking in degree, resulting in a scirrhous type of carcinoma or "inflammatory cancer." The latter type is seen classically in the condition known as "linitis plastica" or "leather bottle stomach."

Diffusely infiltrative cancers arise most often in the stomach but may arise in the breast, in the sigmoid colon, in the prostate, in the lung, or other organs. The primary site is often unrecognizable so that the presence of the cancer is revealed chiefly in its diffuse spread within the organ and in its metastases to other tissues. The disease, though not limited to any one age, is strikingly common in younger patients. Half the cases are seen in patients under 40 and a third in patients under 30.

A number of syndromes can be defined in diffusely infiltrative carcinoma. The primary focus is often silent so that symptoms result chiefly from complications. For example it may take the form of *pyloric stenosis.* X-ray will show diffuse contraction of much of the stomach, especially its distal segment, and often marked narrowing of the pylorus. Ulceration of the mucosa may be present but is generally shallow. Surprisingly some of the ulcers will heal and give the misleading radiologic impression of benign ulceration. Bleeding is uncommon because of the submucosal spread and in many cases the stool is negative for blood in chemical tests. When the whole stomach is involved the picture becomes the classical "leather bottle stomach" or "linitis plastica."

*From the Middlesex General Hospital, New Brunswick, New Jersey.

An *intestinal syndrome* is often seen in cases of linitis plastica. This results from metastases to the small and large intestine in which they produce segmental obstruction. The infiltration in the bowel reproduces the structure of the primary lesion in the stomach, i.e. producing a diffuse infiltration and contraction of the entire wall without ulceration or tumor mass formation. Intestinal obstruction may result. In one such case obstruction of the third part of the duodenum produced *obstructive jaundice* because of entrapment of bile between the constricted pylorus and the secondary lesion in the duodenum.

Another syndrome is represented in the well known *Krukenberg tumor* of the ovaries. Both ovaries are greatly enlarged and may be knobby or smoothly rounded. Microscopically each ovary is infiltrated with innumerable tumor cells occurring singly or in small groups. In some cases the stromal reaction is unusually abundant, so that the enlarged ovary becomes extremely hard, resembling a fibroma. In a few such cases the proliferated ovarian stroma may become the source of *secondary hormone production* because of the intrinsic tendency of ovarian stroma to produce steroid hormones. Luteinization produced by metastatic cancer of the ovary has been reported clinically as a cause of masculinization or of menstrual abnormality.

One of the most interesting types of metastatic lesion is seen in the lung. In such cases x-ray findings may be vague or indefinite. In other cases the picture may simulate miliary tuberculosis although the individual lesions tend to be linear rather than nodular. Clinically the picture is characterized by rapid shallow breathing, progressive cyanosis, and eventual right heart failure (*subacute cor pulmonale*). Microscopically these changes are explained by the tumor infiltration in the perivascular lymphatics, usually exciting the production of fibrous tissue in the sheath of the artery and in some cases also in the intima (*obliterative endarteritis*). The tumor cells often invade the entire thickness of the wall to produce carcinomatous obliterative endarteritis and endophlebitis.

Surprisingly, invasion of the liver is often lacking in these tumors. In a few cases, however, the liver is extensively invaded and the secondary stromal response in the portal fields is striking even when tumor cells are few or apparently lacking. The marginal parenchyma of the liver lobules is often stimulated to produce large numbers of "bile duct sprouts." *Portal obstruction* may occur and in certain cases portal hypertension will produce congestive enlargement of the spleen.

The hematologic complications of this type of tumor are often bizarre and misleading. In some cases widespread invasion of the bone marrow may produce a picture resembling myelofibrosis (*osteosclerotic anemia*), in which numerous nucleated erythrocytes appear in the circulating blood. Anemia is common and may be either macrocytic, *mimicking pernicious anemia* but refractory to therapy, or may be *hemolytic. Leukopenia* or *leukocytosis* may occur, and many immature forms, even myeloblasts, may appear in the circulating blood, suggesting *"aleukemic leukemia."* Thrombocytopenia is not uncommon and may result in typical *purpura.* In some cases enlargement of the spleen is due to myeloid metaplasia.

Less common types of metastasis include diffuse infiltration of the pancreas which may, in rare instances, produce a mild form of *diabetes mellitus,* widespread infiltration of the nerve roots and meninges, producing a picture of *polyneuritis* or Guillain-Barré syndrome, or invasion of the adrenals producing *Addison's disease.*

Because of the rapid spread of these tumors, one can hope for little in the way of complete cure. Palliative treatment may prolong life and comfort for a long period of time inasmuch as these tumors are not prone to ulceration or necrosis. Whether they may respond to chemotherapy remains to be determined.

180 Somerset Street

In this brief compass, Dr. Comer offers a compact monograph on prolapse.

Treatment Of Uterovaginal Prolapse

Thomas P. Comer, M.D./Montclair

Let me describe a 26 year old gravida II para II female with a symptomatic prolapse that needs surgical repair. She wishes to have more children. What operation would you choose?

Normally the uterus lies in a horizontal position. When it deviates posteriorly from this, it is "in retroversion." First degree retroversion includes all deviations from the anterior position in which the cervix-corpus axis points anterior to the axis of the vagina. When the cervix and corpus point directly along the axis of the vagina, the retroversion is of the "second degree." Any deviations beyond this are termed "third degree." You can see why the uterus must be in retroversion before it can prolapse.

When the uterus descends down the vaginal canal so that it lies below its normal position, it is said to be prolapsed. In *first degree* prolapse the uterus is below its normal level, but the cervix does not protrude through the introitus. In *second degree,* the cervix is presenting at or through the introitus. In *third degree,* the entire uterus is projecting. Prolapse is frequently associated with relaxation of the anterior vaginal wall — cystocele; posterior vaginal wall — rectocele; and herniation through the pouch of Douglas — enterocele. It may be necessary to examine the woman in the standing position to demonstrate these relaxations.

Prolapse is associated with the trauma of delivery and with old age. Obesity, strenuous occupational activities, and chronic cough may all play a part. It occurs less commonly in Negro females.

Women with prolapse have a dragging or "falling out" sensation in the pelvis and often complain of "sitting on a ball." Musculoskeletal symptoms like backache, gastrointestinal symptoms such as constipation and urinary complaints such as cystitis are almost never caused by prolapse. Inform the patient that these symptoms will not be relieved by surgery for prolapse, and it is best to have them investigated separately.

Why does prolapse occur? First we must ask another question. What is the primary support of the uterus? Some credit the pelvic musculature consisting of the levator ani with its levator plate, the overlapping of the pubococcygeus and ileococcygeus posteriorly with the added support of the urogenital diaphragm with its supporting musculature below the levators. Others suggest that it is the endopelvic fascia and its ligamentous thickenings. There is experimental and clinical evidence supporting both views.

The injecting of contrast material into the levators and x-rays of women with normal support and with prolapse have shown the necessity of a strong horizontal levator plate for support; and have demonstrated that with increased straining, the uterus is pushed against the levator plate and *not* down the vaginal vault.[1] Clinical evidence to support the importance of perineal musculature in uterine prolapse has been the favorable response to perineal musculature exercises.

Experimental and clinical evidence of the importance of the endopelvic fascia is equally impressive. Some even deny the existence of endopelvic fascia and have presented microscopic sections to support this claim.[2] Detailed dissections of the pelvis, however, do show this fascia and its ligamentous thickenings. The ligament supporting the uterus is one continuous band of condensed endopelvic fascia, the uppermost portion being the round ligament which contains smooth muscle and has its function mainly in labor. Below the round ligament is the broad ligament, the lower portion of which blends with the thickenings about the uterine vessels which are known as Mackenrodt's ligaments or the cardinal ligaments. From the superior view one sees that the cardinals insert more posteriorly than laterally. This goes along with the embryologic development from the posterior abdominal wall and the fact that they are thickenings about blood vessels which come in posteriorly.

A study was performed on fresh cadavers in which weights were attached to the cervix by a pulley mechanism. Upon cutting the round, broad and uterosacral ligaments, the uterus remained in its normal position. When the cardinal ligaments were sectioned, the uterus went into descensus.[3]

Clinically there have been reported cases of congenital absence of the levators with good uterine support.

Thus, there is good evidence for both theories. Perhaps the best explanation is given by those who feel that in the young woman the support is muscular, but with increasing age and atony of the perineal musculature, the endopelvic fascia and its ligamentous condensations become more developed and assume the primary role in support.

Treatment of uterine prolapse often may be accomplished by nonoperative means. Exercises, hormones and pessaries are available.

In 1948 Kegel[4] applied the knowledge obtained in the rehabilitation of poliomyelitis victims and of veterans to the development of what has come to be known as Kegel exercises for restoration of the perineum. Realizing the psychologic value of being able visually to appreciate day by day progress in muscle exercise, he developed the perineometer. A resilient obturator is placed in the vagina, and the woman compresses it with her perineal muscles. The tubing is long enough so that the manometer may be held in the patient's hand. Often in a period as short as one to three months, women have increased their constricting power from 20 to 100 millimeters of mercury. Kegel[4] cited excellent results. In many large institutions on the West Coast women are not considered for surgery unless they have had a three month trial of exercise. This may also be used postoperatively to augment surgery.

In 1948 Anderson[5] reported four patients with prolapse treated with oral estrogens with 100 per cent rehabilitation. The study is frequently quoted, but it is inconclusive. A larger one should be accomplished to establish the effect of estrogen on the uterine supporting tissues.

Another conservative method is the pessary. With improvements in medical diagnosis, methods of anesthesia, and operative technic, there is only the rare occasion for its use, but it should remain in the armamentarium of the practicing gynecologist, for it is true today as it was at the turn of the century when James Marion Sims[6] said, "Pessaries are a necessary evil". Interestingly, the term "pessary" originally was employed for a vehicle containing medications for vaginal application. The Hippocratic Oath, in fact, states that "and in like manner I will not give to a woman a pessary to produce abortion". Earlier treatment of prolapse included cold Sitz baths and the introduction of gonorrheal exudate into the vagina.

Vaginal and perineal surgery began with the repair of perineal tears secondary to birth trauma. Early operations were without anesthesia and asepsis and therefore were comparatively simple. From perineorrhaphy, posterior and then anterior vaginal wall repair

developed as a means of constricting the vagina with a view to controlling vaginal and uterine prolapse. The supports of the genital organs were then a mystery, and the causes of prolapse were unknown. Partial closure of the vagina was devised as a purely empirical method of treatment. Early efforts in this direction consisted of the physical and chemical burning of the vaginal walls in the hope of making them adhere to one another. The surgical accomplishment of this was popularized in 1877 by LeFort[7] who removed small strips of the anterior and posterior vaginal wall and approximated them. This has become the "LeFort operation." Despite the disadvantage of interfering with the vaginal coital function and rendering the uterus subsequently inaccessible by vaginal approach, the simplicity and safety of the operation still commend it for the correction of uterine prolapse in the elderly and poor risk patient. Goodall and Power[8] modified the operation so that just the upper one-third of the vault is approximated permitting fairly satisfactory coitus. An interesting complication of the classic LeFort operation is urinary incontinence secondary to pulling the anterior vaginal wall posteriorly.

The surgical development of the treatment of uterine prolapse during the mid nineteenth century, can be summarized in the words of Thomas[9] who, in 1869 said, "Upon the posterior vaginal wall rests the anterior, and upon this the bladder, and against the bladder lies the uterus, all of which depend in a great degree for the support of the perineal body. The perineal body is truly the keystone of the arch on which the uterus is supported in the pelvis."

It is to Archibald Donald of Manchester, England, that credit is given for combining previous individual procedures into one successful operation.[9] Manchester is at the hub of one of England's major industrial districts whose atmosphere is constantly contaminated with bronchial irritants. Cough is endemic in the area. The wheels of Manchester's industry are turned in a large part by women long accustomed to physical labor. This environment has continued to yield year in and year out a gynecologic clientele overflowing with cases of uterine prolapse. In 1888 Donald[9] combined cervical amputation with anterior and posterior repair which had previously been done separately into a single successful operation.

At the end of the century a further important contribution was made when Mackenrodt[10] accurately described the cardinal ligaments and suggested their importance in uterine support.

Armed with this knowledge, Fothergill,[9] while recognizing the empirical value of Donald's operation, modified it so that the cardinal ligaments were brought anterior to the cervix, thus shortening them and moving the cervix posteriorly so that the uterus might lie in a more normal position. This "Manchester Operation" is still the treatment of choice in many large eastern centers, as it has the advantages over vaginal hysterectomy of shorter operating time with the less blood loss, morbidity, and mortality. These advantages are felt to exceed the disadvantage of the possible later development of endometrial carcinoma from the retained uterus. Although successful pregnancy is still possible, the problems of cervical stenosis and incompetence make it unlikely.

In 1899 Watkins[10] described the interposition operation which bears his name. This consisted of bringing the uterus anteriorly under the bladder. Some gynecologists regard it as the procedure of choice in an occasional case of uterine descensus with large cystocele and normal corpus, especially in the elderly or poor risk patient. Needless to say pregnancy here would be disastrous.

At the same time, Webster[11] reported an abdominal approach in the way of a suspension operation that consists of drawing a knuckle of each round ligament behind the uterus through a perforation made in the broad ligament and suturing the round ligaments posterior to the corpus thereby supporting the latter in an anterior position. This report was a model of brevity, the entire text and an illustration comprising but one column of one page in *The Journal of the American Medical*

Association in 1901. Today the suspension is known as the Baldy-Webster operation, and Baldy's association with it appears to be based upon the vigor of his writings and his bold personality rather than upon his contribution to the operation.

In 1915 Charles Mayo[12] described vaginal hysterectomy as the treatment for prolapse. He mentions success in selected cases with the interposition operation and the suspension operation of the type done by Kocher[21], which involved suturing the uterus to the anterior abdominal wall. The Mayo operation[12] involved *en masse* clamping of the ligaments bringing all the ligaments anteriorly to create a sling for the bladder, but this left an unprotected cul de sac for a potential enterocele.

In 1937, Richardson[13] described a composite operation for prolapse. It was later called to his attention that Spaulding had described a similar operation in 1919, and it has come to be known as the Spaulding-Richardson composite operation. It consists essentially of cervical amputation, corpus removal at any level desired, the utilization of the isthmic portion of the uterus with its broad and uterosacral ligament attachments for support. The advantage of this operation is that the blood supply to the supporting structures remains intact. This is still a popular operation in Baltimore.

Treatment for prolapse at the Mayo Clinic[14] is vaginal hysterectomy by what is known as the Heany-technic[15] first described in 1942. It consists of the individual isolation, clamping, and ligation of the ligaments on either side of the uterus. This is combined with anterior and posterior vaginal vault repair, the feeling being that the best support is from a well constructed vaginal tube.

There is still the problem of the potential enterocele which can be managed by several methods including the modified McCall stitch as described by Symmonds.[16] He calls this the Torpin-Waters-McCall repair. It consists of combining the excision of the peritoneal sac and redundant posterior wall as described by Torpin[17] with the large wedge resection of the posterior wall as outlined by Waters[18] along with the suspension by the uterosacral ligaments advocated by McCall.[19]

One may hear it said that the only treatment for uterine prolapse is vaginal hysterectomy.

What was done for the 26 year old female gravida II para II who presented herself at a large Eastern Medical Center with symptomatic uterine prolapse and who wished to have more children? Being familiar with the problems of cervical incompetence and stenosis of the Manchester operation, it was discarded. They went back 50 years in their thinking and did a suspension. Their thinking went back further — 100 years, as they repaired the perineum, the keystone of the pelvis.

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333 Park Street

There seems to be only one way of relieving the excess of skin associated with the sagging face: surgical excision of the excess.

The Sagging Face

D. McCullagh Mayer, M.D./Rutherford

The "sagging face" is produced by a relaxation or redundancy of the skin of the face and neck termed, *cutis laxa* or dermatoloysis. By this process an excess is produced, represented by the folds of skin drooping, especially about the cheeks and neck. This excess of skin can be removed only by excision. Distinguish between *cutis laxa* and rhytidosis or wrinkling of the skin. While the former may produce the latter the treatment may be by different methods.

If the skin is relaxed and drooping, certain folds or wrinkles will occur. On the other hand, wrinkles may be present without excess skin. If there is an excess of skin, the only way to overcome the excess is by removing it. This implies excision, a surgical procedure.

Improvement of the aging face may be accomplished by surgery, "facial dermatoplasty." Rhytidoplasty refers to the operation upon wrinkles. Other procedures may be employed in conjunction with the surgical face lift or independently. The "chemical peel" consists of applying excoriating chemicals on the skin of the face to cause a peeling of the upper layers resulting in a reduction or obliteration of wrinkles.

Dermabrasion consists of abrading the skin with abrasive materials on revolving wheels, or cones, or with ordinary sandpaper by hand. This is used to treat acne, pock marks, scars, and wrinkles.

A combination of either of the above with the surgical effort may be considered. This is often indicated to reduce the wrinkled skin for which surgery alone may not be beneficial.

Of primary consideration is the reason the prospective patient desires the younger look. Evaluate the possibilities presented and the results to be expected. Some patients will want the younger look for business reasons. It may be helpful to them in their occupation or profession. It may be pure vanity. Or it may be an attempted escape from some deep-seated frustration or from some mental problem. Even the most successful surgery will not overcome the latter.

After considering all of the possibilities and expectations, the entire procedure should be carefully explained to the patient. Not every applicant is a good candidate for surgery. Those who are not good candidates should be so advised.

Facial dermatoplasty is always done under local anesthesia on our service. This is readily accomplished if the patient is adequately sedated pre-operatively and the local anesthetic is administered properly. This avoids the hazards sometimes associated with general anesthia. In addition, access to the surgical field is free of cumbersome anesthesia equipment.

Other surgical procedures such as blepharoplasty to overcome redundancy of the eyelids may be considered to enhance the facial dermatoplasty.

* Read before the Section on Plastic and Reconstructive Surgery, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1969.

170 Ridge Road

Truly comprehensive, family-oriented medical care is no pipe dream, but a practical reality for a state like ours, suggests Professor Smith.

Where Do We Go From Here?

Thoughts On The Delivery of Pediatric Care*

Hugo D. Smith, M.D./Cincinnati, Ohio

Recent spectacular advances in medical science together with rapid methods of communication to an increasingly sophisticated lay public have resulted in an aura of fantastic potentials for modern medicine plus a clamor for top quality care for everyone. Although these expectations may be unrealistic, they are becoming increasingly vocal and, if not respected (or met with constructive alternatives), may result in the delivery of medical care becoming a political football influenced in its flight more by the wind from the voices of the crowd than by educated quarterbacks of organized medicine. Among the new concepts concerning ways to improve medical care are three for which pediatricians have provided much of the creativity and leadership: comprehensive care, community pediatrics, and family care.

These questions would appear to me to present as many challenges to New Jersey (with its high density urban population and its more widely scattered semi-rural population) as to any other state of the union. Furthermore, pediatricians, health officers, public health nurses, hospital trustees, and other altruistic citizens of the state have as great an opportunity and potential to provide realistic and effective answers as do their peers elsewhere in the country.

Family care appears to refer to a form of delivery of health care to all members of the family—both children and parents—provided under one roof by individual physicians or teams of physicians working in such a fashion that the emotional and physical interactions of disease and stresses within the family are respected. In clinics providing family care there may even be a single family chart containing individual records for each member. The care can be provided by a family physician who knows all the family and thus can see the interactions of disease and emotions. The care may also be accomplished by a team, usually internist, pediatrician, and obstetrician, who meet together repeatedly to coordinate their knowledge concerning the various family members. To this team may be added nurse practitioners who offer much of the primary care to all the members of a given family, public health nurses, and social workers.

Community pediatrics is a new, unique, and important concept. Traditionally the delivery of medical care has been thought of in terms of the people who have come voluntarily to the hospital, clinic, or physician and little thought has been given to the people who failed to seek medical care. Physicians delivering community pediatric care think instead in terms of the health of an entire population, both those who do and those who don't come for care. Thus success or failure is measured in terms of all the people of an area, not just those motivated to seek medical attention. Community pediatrics, therefore, attempts to make sure that all the children in an area

* Presented January 24, 1969 at the Visiting Professor Conference of the Monmouth Medical Center, Long Branch, New Jersey. This work is from the Children's Hospital Research Foundation and the Department of Pediatrics, University of Cincinnati College of Medicine, Cincinnati, Ohio 45229.

have appropriate care. An extension of community pediatrics is the effort to provide much of the care on a neighborhood basis, with the aim of making the care readily accessible, of being sensitive to the local consumer needs, and of understanding the mores of the consumer population.

Comprehensive care generally is considered to include both the management (on an ambulatory or outpatient level) of acute episodes of trauma and disease and a major effort at the prevention of disease and disability. The latter effort has broad possibilities: the early recognition and treatment of disease, utilizing screening technics for vision, hearing, reading difficulties, anemia, PKU, and so on, plus counseling concerning diet, dental care, sex education, and psychological development; family planning and conception counsel; accident prevention; efforts to prevent the initiation of the smoking habit; fostering the intake of fluoride; and, of course, the traditional immunization programs. Many people believe that even more should be involved in comprehensive care, in particular, that it should include improving the environment too. In our outpatient clinic, we encourage parents from culturally disadvantaged groups to provide a more intellectually stimulating environment through reading, singing, and talking with their children. On a wider scale are the endeavors to improve neighborhood cleanliness, to eradicate rats, and to decrease air pollution. The greatest effort in comprehensive care I know (and there are many examples) is the program of Dr. W. L. Mellon at the Hôpital Albert Schweitzer in Haiti. Dr. and Mrs. Mellon initiated their project with the aim of "relieving suffering" through the provision of high quality traditional medical care. Quite rapidly they realized that the medical care was not getting at the real cause for suffering and thus they were only changing the timing of the suffering. Accordingly their program was gradually extended to immunizations and then such things as sanitation (including good wells, decent privies, and proper location of each to the other), improved water, better farming, and even decent cooking and laundry. Currently less than half of the hospital's budget goes for what traditionally might be considered medical care.

Although comprehensive care frequently is thought of solely in a pediatric setting, the Mellon program indicates it can be given on a community basis. I learned from Mrs. Mary Breckenridge, a nurse-midwife who created the Frontier Nursing Service in eastern Kentucky, that others believe that optimal realization of a child's health potential is dependent upon good emotional and physical health in the parents as well. Thus for maximum efficacy, pediatric comprehensive care should be extended to family comprehensive care.

The general public, and the politicians who respond to them, seem to be demanding a change in the format of the delivery of health care; and if comprehensive, family, and community care are among the choices for the future, it is of major importance that there be critical evaluation of the effectiveness of these programs. In this era of public discontent with inflation and high taxes, the evaluations should include cost in relation to results. Such studies as have been reported to date suggest there are real benefits to preventive, comprehensive care programs. Thus the preliminary analyses[1] from Dr. Joel Alpert's family care program at Harvard indicate an initial increase in hospitalizations and operations but a long term (over 3 year period) decrease in hospitalizations, operations, and emergency room visits for those entering the program as compared to matched controls. Although the total number of visits to the doctor were comparable for the study and control groups, it appears certain that a great financial saving must have resulted from the decrease in hospital-days and operations. Other measures of well-being and productivity remain to be reported. The Columbia Point program of Tufts Medical School[2] likewise is beginning to report some parameters of improved care. The availability of medical care has a great influence on how readily medical assistance is sought. Prior to the start of the Columbia Point project, only 72 per cent of the people in that area of Boston considered that adequate medical care was available to

them. The cost in terms of time was high since 70 per cent of them needed between 2 and 5 hours to get to a clinic or emergency room, be seen and cared for, and to return home. Now with the Columbia Point project in full operation, 100 per cent of the people consider good health care to be readily available and 89 per cent report they can achieve care in under one hour, door to door! I hope that those of you in New Jersey who are developing plans to provide improved medical care for everyone in your burgeoning population will pay special attention to the need to document the efficacy of your efforts.

A further question that requires attention is, who will actually provide the health care?

The traditional form of solo general or pediatric practice appears archaic as it is too demanding of the physician in terms of telephone calls and lack of time off. It is restrictive in terms of time for continuing education. It does not allow for an area of special knowledge which helps support intellectual morale, and, as shown by the studies of Connelly and Yankauer[3] it does not foster efficient use of the physician's time through the assistance of allied health personnel. The partnership of two to four pediatricians permits more control of one's time with defined off-duty hours, encourages areas of special competence with one partner, as an example, doing cardiology as a hobby and another allergy, and permits use of nurse practitioners, social workers, and (as in Dr. Burton Breese's practice in Rochester, New York) even bacteriologists. But the average suburban pediatric team cannot provide true family care and lacks the stimulation and rewards that come from caring for the wide spectrum of disorders seen when one cares for a broad, economic segment of the population. Other current forms of health care are the outpatient clinics of teaching hospitals and the neighborhood clinics of health departments. Hospitals have many subspecialists and laboratories readily available. However, they do not seem to satisfy the medical public or the medical students as there is little or no continuity of doctor-patient relation. Furthermore, the care is not conveniently available in terms of location or time required. Neighborhood clinics, while convenient, generally lack sophistication of care and commonly are open only a few hours a week. Neither type considers the family as a unit.

A growing number of groups exist, such as the Exeter, New Hampshire Clinic, where generalists, internists, pediatricians, obstetricians, and surgeons are allied to provide both inpatient and outpatient care, treatment of acute episodes and preventive care, and care for all age groups. Although many of these are not currently oriented towards family medicine, they have this potential and already frequently display much communication between physicians caring for the various members of a family. Some of these, such as the Permanente Groups on the west coast, offer prepaid comprehensive care. They could readily accept a government contract to include the medically indigent among those for whom they offer care. In areas of high population density, this type of medical alliance would appear to me to have the best potential for providing community, comprehensive care in the next few decades. To be successful the groups must be readily available to their patients even if this means developing a system of mini-buses. Also, there must be extensive use of nurse practitioners and other allied health personnel so as to get the greatest productivity from the physicians at a minimum of cost to the patient. These clinics, while doing very well at the primary and secondary levels of care, cannot provide *all* aspects of care, especially in the subspecialties and for the very sick. Thus there must also be a system of referral of the very sick, the rare, and the complex to centers for tertiary level care. Because of the greater frequency of severe illness among adults than children, there will be more centers for adults with complex problems. As I understand the situation in New Jersey, the puzzling case, the child with newly diagnosed leukemia, or the child needing open heart surgery must go to centers in New York or Philadelphia. Shortly no doubt similar tertiary care will be available in Newark and extensive support of Dr. Franklin Behrle in his endeavors is in order.

But even of higher priority would be attention to massive planning for the provision and evaluation of primary and secondary level care of a high quality for every person in your state. The challenge is to develop a system of available, comprehensive, family-oriented care which uses the physician with a high degree of efficiency. I can envisage a system of neighborhood clinics staffed largely by family-care-oriented nurse practitioners supported by pediatricians, internists, and obstetricians who, while based in secondary level centers such as the Monmouth Medical Center, could supervise the primary care with occasional on-the-scene consultations or by closed circuit television. Several such secondary centers would in turn be backed by a regional center for tertiary, subspecialty, complex care. Transportation to the primary centers and between centers must be included in an effective health care program.

Comprehensive, family, community care is not a Utopian pipe dream. It is a form of delivery of health care which could be a reality in New Jersey in the not too distant future. Success will require much hard work, extensive planning, a major cooperation among physicians, nurses, hospitals, and health departments, great tolerance and understanding, and finally imagination, courage, and determination. The challenge is great and there is a role for everyone—nurse, physician, health commissioner, hospital trustee, philanthropist, and patient.

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Children's Research Foundation
Cincinnati College of Medicine

Computer Diagnosis Available For Pediatricians

Mead Johnson and Company said it will soon begin marketing a computer for diagnosing child diseases and ailments. Called Computer Assisted Diagnosis, the system was designed by Worley and Ringe, Inc., Philadelphia, who have licensed Mead Johnson to market it.

According to a story in the *Wall Street Journal,* to use the system a physician calls a computer through a teletypewriter installed in his office or at the hospital. The physician then tells the computer what symptoms his patients are manifesting. Each symptom has a code number which is punched into the computer. The computer then compares the physician's findings with those stored in its memory bank and prints out a list of probable diseases. The computer will also list additional symptoms which the physician should look for in determining his diagnosis.

The system should allow for more efficient use of a physician's time, a spokesman for Mead Johnson said.

Until the first of the year the system was offered free on a trial basis to all medical schools, the spokesman said. Now charges are based on the amount of computer time an individual subscriber uses, plus a flat monthly fee for the teletypewriter. Besides medical schools, the system will also be marketed to hospitals, clinics, and group practices specializing in pediatrics.

—*AMA News,* October 20, 1969

Here offered is a simple but clear blueprint to help New Jersey doctors meet their responsibilities to our school children.

Hearing Screening Programs In Mercer County's Public Schools

Aris M. Sophocles, M.D. and Robert A. Muzzarelli, M.A./Trenton

A study was undertaken to determine the status of hearing screening programs in Mercer County, New Jersey. The aim was to evaluate the effectiveness of such programs in our area. Questionnaires were sent to all the public school districts in the county. No parochial or private schools were included. Response was excellent. The questionnaire allowed for a significant degree of variability in responding to each question, also allowing specific deviations in hearing screening programs to be readily recognized. About 50,000 students were covered in this survey. Here is a summary of our observations from the analysis of the replies.

1. Two school systems reported "no formal hearing screening program except testing on teacher referral basis only." More than 20,000 students had no screening of hearing.

2. We found no uniformity with respect to the school grades screened between school districts and within a given school district. For example, only seventy per cent of the testers (school nurses) screened grades 2 and 4. Yet, the most critical period for detecting hearing problems and ear pathologies is in the age range of 4 to 10 years. Deleting grades 2 and 4 may lead to learning and social problems should loss go undetected.

3. No uniform method is found in frequencies tested. Two schools tested all frequencies including the intermittent frequencies of 750, 1,500, 3,000, and 6,000 Hz. Others reported screening only 500, 1,000, 2,000 and 4000 Hz. Screening all frequencies is undesirable because of the time required as well as increasing the criteria to an almost realistic standard.

4. We found no uniform level of presentation of tones for screening. Some schools reporting indicated that screening levels were as low

Figure 1
Screening Questionnaire

1. Equipment
   a. Type of audiometer used?
   b. Calibration: date last done?
      how often done?
   c. Room in which hearing tests are carried out?
2. Personnel
   a. Total student population?
   b. Number of schools?
   c. Who carries out the screening?
   d. How many done by one individual? In what length of time?
3. Frequency of Screening
   a. Which age groups are covered in your school system?
   b. What classes are screened?
   c. Are the failures rechecked prior to consultation?
4. Technic
   a. Which frequencies are screened?
   b. Are you interested in going over technic with committee members?
5. Recording of Results
   a. Is a note made on each health record as to screening results obtained?
   b. Is a record made of notices sent to parents?
   c. Is a record kept of the follow-up on reports to parents and physicians?
   d. Is there a record of the physician's recommendations?
6. Forms Requesting Consultation
   a. Can you supply us with a copy of the form used to notify the parents?
   b. And, of the blank submitted to the doctor?

*Mr. Muzzarelli is the audiologist at the Mercer County Speech and Hearing Center. Dr. Sophocles is chairman of the Mercer County Medical Society Committee on Conservation of Hearing and Vision.

Figure 2

Results of Survey Screening of Hearing in Mercer County

School District	Population	Screening	Method of Follow-Up	Effectiveness
"A"	3,039	Good	Good	Good
"B"	5,862	Inadequate	Poor	Poor
"C"	14,570	None	None	Very poor
"D"	3,273	Good	Good	Good
"E"	3,625	Poor	Poor	Poor
"F"	5,110	Excellent	Excellent	Excellent
"G"	511	No reply	No reply	No measure
"H"	942	No reply	No reply	No measure
"I"	17,706	Good	Poor	Poor

as 10 db (ISO Standards) to as high as 30 db "depending upon the level of ambient noise." Unless a sound level meter is available, a decision of screening level should not be arbitrary.

5. Only two audiometers were reported available in one school system of 15,000. If each school in this system were to have an audiometer, there should be a total of about twenty. This brings up the question of inadequate funds for equipment made available by the Board of Education.

6. Periodic calibration of audiometers is not made. Although many schools reported that their audiometers were calibrated annually, no allowances were made for audiometers which were continually transported from one school to another.

7. No uniform referral method was followed. Most schools could not report the number of referrals at the end of the year, showing the lack of integration of this information within a school system. Most schools use a form which is sent home. This requires completion by the parent and the examining physician. However, other schools used no forms but depended on contact with the parent by telephones. They then asked that the child be seen by his physician.

8. General effectiveness of screening was found extremely poor in 60 per cent of this school population. In 10 per cent of this population, the screening and follow through could be classed as good to excellent. With improper follow-ups, it is questionable whether a screening system has a goal worth pursuing at all.

The following recommendations are here offered as a basis for a more uniform program of screening:

1. It is recommended that the following grades be screened every year: K, 1, 2, 3, 4, 5, 7, 9, and 11. Further, screening should be done on all referrals (teachers, physicians, parents, or others) for: children known to have had a hearing problem at one time; new pupils entering school; and those returning to school after a serious illness (especially upper respiratory disorders).

2. The following frequencies as well as order of presentation are recommended for a formal and uniform hearing screening program: 1,000; 2,000; 3,000; 4,000; 1,000; and 500 Hz. This presentation should occur when testing one ear and then when testing the opposite ear.

3. The screening level as suggested by American Speech and Hearing Association is 25 db (ISO - 1964 Standards). This will allow for ambient noises in the testing environment and it will differentiate between possible hearing problems and normal hearing. It is also suggested that all audiometers now be calibrated to the new ISO Standard in preference to the old ASA Standard.

4. Because of the effect of continual handling and jarring on the calibration of an audi-

ometer, it is recommended that:

a. Each school have its own screening audiometer;

b. Audiometers used in more than one school be calibrated at the beginning of the school year (late August or early September) and be checked again in mid-year (February). The initial calibration should be by a skilled engineer or by the manufacturer. The mid-year calibration check can be done on ten individuals known to have normal hearing thresholds.

5. Results of the screening should be reported on a standardized form. The form should allow the physician to report readily the type of hearing loss, degree of severity, stability, diagnosis, cause, prognosis, and recommendations. In this way, the school can then initiate steps to assist the child in his academic and social work. A copy of such a form is displayed in figure 3.

6. The criteria for failure of a hearing screening test should be failure of two frequencies at 25 db ISO or more in one ear; or if both ears suffer with a loss of 25 db ISO or more in any one frequency in each ear.

Conclusion

A formal program for screening of hearing in the public schools of New Jersey is offered for establishing a more effective program than now exists. State law does provide for health examinations in the schools but there is no uniform implementation. Screening of hearing is lacking in many counties in our state. Remedies have been sporadic in the form of a study by the Crippled Children's Program and its recommendations. One hopeful sign is the organization of courses in some of our colleges instructing nurses on how to carry out screening programs in their schools. School superintendents have shown some interest in the need for a uniform program of screening. This effort, however, evaporates a cloud of confusion and inactivity when confronted by a Board of Education that fails to provide funds for equipment; or by personnel who are not properly equipped or inspired.

2. The Committee of the Mercer County Medical Society which has carried out the study in the public schools of our county has recommended that the State Department of Education take a hand in implementing the health program in our schools as it pertains to the early discovery of hearing problems in our children. To do this adequately, it must spell out a required screening program to be done uniformly throughout the State. The medical profession has been aware of the lack of screening or the very poor screening done in our schools for many years. We look with embarrassment at programs in some of our neighboring states. Effective screening means

Figure 3

NAME AND ADDRESS OF SCHOOL

Student:_____ Grade_____

A recent hearing screening test on your child showed the need for a more detailed examination. In the interest of your child, it is recommended that you consult your family physician for a *complete ear examination.*

Please have the doctor complete the form below and return to the school.

Thank you,

_____

Date:_____

Patient:_____

Examination

1. Pathology of hearing mechanism (describe):
Ear canal_____

Tympanic membrane_____

_____

Presence or absence of wax, discharge or other pathology_____

_____

2. Cause(s) of condition_____

_____

3. Type of hearing problem_____

_____

4. Stability of hearing condition_____

_____

Recommendations and prognosis:

1. Medical and/or surgical treatment_____

_____

2. Prognosis_____

_____

3. Educational recommendations (special seating, further diagnostic hearing tests, hearing aid, limitations in school activities, etc.):

_____ M.D.

discovering children with early hearing loss at a time when it can be corrected. This would prevent many of the more advanced and irrevocable hearing losses.

3. Until proper legislation can force our schools to take effective interest in this matter, the physicians of our State are urged to look into this situation in their own towns. With the high cost of special classes for the severely handicapped, the taxpayer's contribution will be much less should the hearing loss be discovered early. We are dealing with large numbers. Five per cent of students will need special facilities should their hearing be allowed to deteriorate.

4. As taxpayers and physicians, we must take an interest in the implementation of the standards for screening which the State Department of Education is now including in their School Health Service guidelines.

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Physicians Are Not "Drug-Dumb"

Irving Rubin, Ph.G., answers "no" to the question: "Are physicians drug-dumb?" Following is an editorial which appeared in the November 1969 *Pharmacy Times* (80 Shore Road, Port Washington, New York 11050) written by Mr. Rubin, its editor:

Do physicians continue to prescribe certain drugs—year after year—even though these drugs are ineffective and/or unsafe?

I'd have to answer *Yes*—if I agreed with the Food and Drug Administration's recent stepped-up drive against drugs which practicing physicians have been prescribing for years.

FDA's drive—largely against the products of research-oriented companies—comes at a time when the federal government has announced that the National Institutes of Health is reducing its research grants. Such cuts threaten to close down a number of medical research centers. Certainly, this is *not* the time to pull the rug out from under pharmaceutical companies that — the record shows — have been pioneers in research.

Or . . . could it be that the FDA is 100 per cent correct and the nation's doctors are *not* familiar with the drugs they prescribe? I find it hard to believe that a physician would continue to use drugs—year after year—*if these drugs did not help his patients.* Yet, in net effect, that's what the FDA says has been happening.

I don't believe that doctors are drug-dumb! My vote of confidence goes to the nation's practicing physicians and their experience with drugs.

—Irving Rubin, R.Ph.

Presented here is a case report of a rare combination of bony changes in one individual.

Craniometaphyseal Dysplasia And Osteopetrosis Tarda*

A Rare Combination Of Bone Dysplastic Changes

Richard A. Hurwitz, M.D./Jersey City

Failure to absorb the last stage in the metaphyseal growth process has led to the retention of the secondary spongiosa and the resultant deformity as described by Pyle[1] in 1931. Since then, several cases have been reported. Caffey[2], described a patient with craniometaphyseal dysplasia who had vertebra plana and vertebral body sclerosis not unlike that which is seen in osteosclerosis secondary to renal disease.

It is the purpose of this report to present a patient who has the bony changes of Pyle's disease and in whom there is a distinct bony sclerotic pattern. Such a change may reflect a failure to absorb the primary spongiosa as is seen in osteopetrosis.

A 22 year old man was admitted to Walson Army Hospital complaining of low back pain. He had been in good health until three months prior to admission when he had an ear infection. At the inception of his basic training he noted the onset of low back pain. The patient had had a fracture of the left tibia in 1960, a fracture of the right femur in 1959, a fracture of the left ulna and radius in 1960, and a skull fracture in 1953. As an infant he had a right clavicular fracture. These fractures were caused by relatively slight trauma.

The family is characterized as being of a short stature. The patient has 6 brothers the tallest of whom is only 64 inches. He weighs 130 pounds. One brother has had a fractured clavicle and another has had a broken arm. The patient was 62 inches tall and his weight unclothed was 95 pounds. He showed an inward stooping posture and a narrow chest in the axilla-to-axilla dimension. His head had a beak-like appearance and he was slightly agnathous. The white count of 7,900 was found with 65 per cent neutrophils and 29 per cent lymphocytes. Serology was nonreactive. A carbon dioxide was 30, chlorides were 96, sodium was 142, potassium was 4.9. All of these were in milliequivalence per liter. The calcium was 10.6 milligrams per cent and phosphorous was 4.2 milligrams per cent. A sternal bone marrow was performed which was histologically normal.

Radiographic findings—In the skull and facial bones there is a lack of aeration and pneumatic cell development in both mastoid areas. Bony sclerosis is present in the petrous ridges bilaterally. Rudimentary development of the maxillary sinuses is noticed. There is non-development of the frontal sinuses. Some small anterior ethmoid cells are noted. An oblique orbital view suggested some thickening of the superior and lateral wall of the orbit. The over-all appearance of the facial bones suggested a delicate smallness. The mandible appears to be somewhat smaller than normal. The thoracic and lumbar vertebral column shows bony sclerosis subchondrally on the superior and inferior aspects. The picture is like that of the rugger-jersey spine of osteosclerosis secondary to renal disease. However, vertebral plana is not present as was the case which was described in Caffey's textbook[2]. Incidentally noted was a spondylolisthesis of L-5 on S-1 with a definite defect within the pars interarticularis region. There is a general tendency for



Figure 1—A lack of pneumatization of the mastoid air cells and frontal sinus regions is apparent. Increased bony sclerosis is noted in the mastoid area and in the petrous ridges. A Water's sinus view (not illustrated) shows rudimentary maxillary antra with only partial aeration. The ethmoid cells are rudimentary in terms of aeration. The mandible is of normal size. Increased bony sclerosis is present in the hard palate of the maxilla. The skull is of a normal size.

* From the Department of Radiology, Christ Hospital, Jersey City, New Jersey.

the anterior aspects of the ribs to be slightly splayed. Bony sclerosis is not a distinct feature within the rib cage; but the 7th rib on the right has a definite sclerotic appearance.

Bones of the hands and feet show the same type of changes. Bony sclerosis is noted opposite the major growing portions of these small tubular bones in the



Figure 2—Chest—Bony sclerosis of the right 7th rib. There is suggested splaying of the anterior rib ends.



Figure 3—Splaying of the short tubular bones of the hand opposite the region of the old epiphyses near the growing metaphyseal region is apparent. Note the increased sclerosis at the opposite end of the short tubular bones. The small cuboid bones of the wrists shows that there is a fine sclerotic line paralleling the cortical border in some of the carpal bones. This mimics an *os*-in-*os* effect which is seen primarily in osteopetrosis.



Figure 4—Splaying is again noted at the metaphyseal ends of these short tubular foot bones opposite the area of the old epiphyses. The opposite ends of the metatarsals show some bony sclerosis and suggested cortical thickening.



Figure 5—Splaying and cortical thinning at the distal aspects of the radius and ulna are present. Note the bony sclerosis at the proximal ulnar region. A peculiar bowing of the radius and ulna at the proximal diaphyseal regions is present. This bowing is probably due to stress and strain placed on the bones.

phalanges. Near the area of greatest growth, splaying and lucency with thinning of the cortex are predominant features. At the non-epiphyseal areas of the tubular bones, bony sclerosis is present. This lucent and sclerotic picture occurs in each of the tubular bones in the hands and within the feet so that a broad symmetrical pattern is present. In both wrist regions, there is a simulated *os*-in-*os* effect. A thin rim of sclerotic bone surrounds the entire circumference of these smaller cuboid bones. The picture tends to mimic the *os*-in-*os* effect which is seen in osteopetrosis.

The flat bones show some patchy areas of sclerosis. There is also a suggestion of alternating arcuate bands of increased and normal density parallelling the iliac crest. Patchy areas of bony sclerosis are present within the femoral head and neck regions bilaterally and within the greater trochanter areas as well. An old well healed fracture is present at the proximal right femoral diaphysis below the intertrochanteric line. A Coxa vara deformity is seen in the right hip region. A deformity in the right supra-pubic ramus suggests the presence of old fracture deformity with resultant pelvic contracture. The proximal femoral diaphyses show a markedly narrowed medullary cavity with a thickened cortex. The cylindrization process here suggests a lack of osteoclastic activity reducing endosteal absorption.

The right and left femur at their distal aspects show splaying in the metaphyseal area. There is thinning of the cortex bilaterally. We note alternating bands of sclerosis and lucency throughout a major portion of the metaphysis and metaphyseal-appearing distal diaphysis. This a pseudoexpansion of the metaphyseal region in that all the bone formed as a result of endochondral bone formation persists. The same is noted in the proximal and distal tibial metaphyseal regions; and at the distal radius and proximal humerus. Alternating bands of sclerosis are seen within the proximal humeral region. They are also noted in the distal femoral areas. The peculiar "S" shaped deformity of both tibias results from failure of the bone to withstand normal stress and strain. Medial bowing to the proximal radius and ulna is noted bilaterally which may also suggest a failure of the bone to withstand strain. The distal femur, proximal humerus, ends of the tibia, and the distal radius all have an "Erlenmeyer-flask" deformity. Suggested splaying at the distal ulna is present.

According to Rubin[3], the modeling error appears to be a basic failure of absorption of the secondary spongiosa. The resultant change in the bones, especially the long bones, is in many ways similar to osteopetrosis and results in a splaying of the metaphysis but without associated bony sclerosis.

In this entity, vascular erosion and replacement of calcified cartilaginous elements occur. True osteoid trabeculae are formed. The funnelization process never occurs, and the



Figure 6—Splaying of the metaphyseal regions at the distal right and left femur are apparent. Numerous sclerotic transverse lines are present in the distal femoral regions. The deformity in the proximal diaphysis is the result of a well-healed fracture. The "Erlenmeyer-flask" deformity is present at both distal femurs.

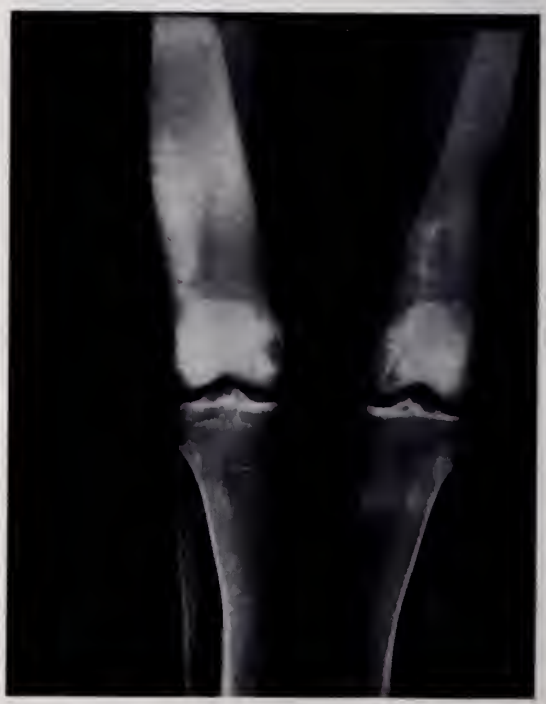


Figure 7—Views of the right and left knee region contrast sharply. Note the malacic appearance with the "Erlenmeyer-flask" deformity at the proximal tibias in which an occasional transverse sclerotic line is apparent. The distal femurs contrast to this change in that there is an increased sclerosis caused by heavy transverse lines in the splayed metaphyseal region.



Figure 8—The classical "Erlenmeyer-flask" deformity with the splaying is present at both aspects of the tibia proximally and distally. The "S" shaped bowing of the tibias results from failure of the bone to withstand normal stresses and strains.



Figure 9—The humerus also reflects the splaying of the proximal diaphysis which is opposite the old rapid growing portion of the bone. Again, increased sclerosis due to transverse lines is present. A near normal appearance characterizes the distal humeral diaphysis.

metaphyseal segment is not incorporated into the diaphyseal cylinder with growth, thereby producing the pseudoexpansion picture of the metaphyseal splaying with its malacic appearance. The thin cortex may explain the radiolucent metaphysis. However, the modeling error proposed suggests that an abnormally calcified spongiosa may be at fault. The sclerosis in the shaft may be a failure of osteoclasis to occur endosteally and so resorb the periosteal bone which had been previously formed.

The localized patchy sclerosis in the pelvis and the extremely broad sclerotic transverse lines of the distal femurs and humeri would suggest a lack of resorption of the primary spongiosa as well. As for variant forms of craniometaphyseal dysplasia there is an expressed linkage of this entity with osteopetrosis. Jackson, *et al.*[4] have suggested that many subvarieties may exist in that there are features in common with osteopetrosis and craniometaphyseal dysplasia. The "rugger-



Figure 10—The pelvis and proximal femoral areas reveal patchy areas of sclerosis. This is seen in both femoral head regions and below the greater trochanter areas bilaterally. In the sacroiliac regions, bony sclerosis of a patchy nature is seen. On the original x-ray, hemi-arcuate sclerosis in the iliac wings was noted. These alternating bands parallel the iliac crest. The apparent deformity to the pelvis is the result of fracture with healing.



Figure 11—This lateral lumbar view shows sclerosis at the inferior and superior aspects of the vertebral bodies. It mimics the picture of osteosclerosis secondary to renal disease. This picture is reminiscent of the "rugger-jersey" spine. A similar type defect was seen in Caffey's case[2].

jersey"-like change in the vertebral column must also be accepted as an unusual feature or variant.

A lack of prominent sclerotic changes in the skull is not difficult to comprehend. There are sufficient changes present to suggest that the skull *does* encompass the disease entity under discussion. True, a lack of mandibular changes is atypical, but this is more than offset by the lack of development of the paranasal sinuses, the lack of pneumatization of the mastoids, and the bony sclerosis of the petrous ridges and hard palate.

The radiographic changes are striking. The long tubular bones demonstrate a widening of the metaphyseal areas causing a curious "Erlenmeyer-flask" deformity. The cortex of these long bones is markedly thinned in the metaphyseal area. A delicate trabecular appearance in association with the malacic radiographic picture is noted here. This kind of splaying (or pseudoexpansion) is also seen in Gaucher's disease, osteopetrosis, and heavy metal intoxication, the most common of which is lead.

Pease and Newton[5] have postulated that chronic insidious lead intoxication may be the cause of craniometaphyseal dysplasia. Rubins criticism[3], at first glance, would lead one to dismiss this theoretical probability. In the present case, we saw heavy and prominent sclerotic lines in the femoral and humeral metaphyseal regions. Therefore, the criticism regarding the heavy lines in the metaphysis of the plumbism cases (as not being seen in craniometaphyseal) may be refuted. The lack of gross splaying in the plumbism cases may be due to the fact that the cases were all in children in the 1 to 5 age group, in whom significant bony growth in the long bones had not taken place and splaying is not as dramatic as may be expected later.

Unfortunately in the present case blood



Figure 12—The bony sclerosis of the superior and inferior aspect of the vertebral body produces, on this AP view, an appearance suggesting an *os*-in-*os* in bone effect.

levels for lead were not obtained. Even so, one would not expect to find positive blood levels in so old an individual.

The siblings in this present case are all of small stature. These siblings could not be evaluated radiographically.

The mid diaphyseal portion of the long bones tends toward a normal width and shows some tendency toward a cortical thickness approaching normal. Long bones (in which stresses and strains are applied), may show peculiar bowing. A prime example is the "S"-shaped curvature seen in the tibias. Flaring may be observed in the anterior rib aspects and at the proximal clavicles. The mastoid processes may not be pneumatized, nor may there be pneumatization of the paranasal sinuses except for vestigial maxillary antral cells.

Conclusion

1. The present case has the major classical bony changes that have previously been recorded in craniometaphyseal dysplasia.

2. Striking features are seen in the long tubular bones in which the splaying of the metaphyseal portions of the bones is recognized, along with the malacic appearance and cortical thinning.

3. The unusual manifestations as seen with this case is that a patchy sclerosis is present in the pelvis and proximal femoral areas. A "rugger-jersey"-like picture of the lumbar spine suggests secondary renal osteosclerosis. Heavy transverse sclerotic growth lines are also pictured in the distal femoral and Proximal humeral regions. It is postulated that not only is there a failure to absorb secondary spongiosa in this case, but that a failure may also exist in the absorption of the primary spongiosa, thereby allowing the isolated bony sclerotic areas to be radiographically visible.

4. Other bony changes include the same splaying of the metaphyseal ends of the small tubular bones, and bowing of bones following stresses and strains that are normally present. Skull changes of osteosclerosis were encountered as was the lack of aeration in the sinuses and mastoids.

I thank Dr. Philip Rubin, Professor of Radiology at the University of Rochester, for reviewing this manuscript and concurring with the conclusions herein stated.

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8 Clifton Place

204th ANNUAL MEETING

May 16-19, 1970 Atlantic City

Adolescents, perhaps, are losing confidence in our ability, as adults, to solve the problems of a world that the adolescents never made.

Adolescents And Their Problems With Society*

Malvina W. Kremer, M.D./New York

Adolescence is a distinct phase in the life history of the individual. The full clinical implications of this fact are only now beginning to be appreciated, largely perhaps because of the activities of the adolescents themselves. Adolescents have presented a problem to society throughout history. We find in the writings of Aristotle, Socrates, and others of the ancient world complaints and descriptions of adolescent behavior which read as though they were written for today. But while there are resemblances to our present predicament in these older writings, we see today many new developments which have few historical counterparts.

The developmental tasks of childhood are largely intra-organismic. At the outset, the basic tasks involve the maturation and integration of perceptual and motor processes and the fundamental technics of communication. This is the period of the establishment of basic functions of ego control and the organization of fundamental patterns of emotional reactivity. During the latter part of childhood, the child begins to emerge from the nexus of the family and to find his bearings in the outside world. In primitive cultures, the latter part of childhood is also the time for acquiring some of the skills necessary for survival, such as the tracking and hunting of game, methods of fishing and navigation, and so on.

Sexual maturation, which is the hallmark of adolescence, is the aspect of this period which has received the greatest attention. New developmental tasks of adolescence, however, extend far beyond the establishment of definitive patterns of sexual behavior. This is the period which requires that the child begin to take on adult responsibilities which will lead ultimately to full independence. It is the period for establishing a definitive role in life, a task which requires the acquisition and refinement of additional skills and functions. A further task is the consolidation of necessary controls and constraints which enable the individual to live more or less harmoniously within his particular community. These tasks represent the completion of the process of enculturation, to borrow a term favored by our colleagues in the field of anthropology. An essential part of enculturation is the incorporation of the systems of myths and beliefs and the framework of institutionalized values and standards which characterize each society. In primitive cultures the lore of the tribe or clan is transmitted directly by the elders. In our own society, the task is far more complex and is divided among many agencies: family, schools and colleges, religious institutions, and the media of mass communication. The net result in the various cultures is an American, a Bushman, or an Athenian, as the case may be. Socrates and Aristotle complained about the adolescents of their times, but there is no indication that these young people were anything but Athenians in all truly significant aspects. What we are witnessing today is not merely friction with elders, disrespect for authority, or premature assertion of independence. Each era and each society has its rebels and deviants, some of whom are constructive

* Read before the Section on Psychiatry and Neurology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 19, 1969.

and innovative, others merely rebellious. But these rebels and deviants remain, for the most part, within the framework of their society. What we are seeing today, what is unprecedented, is the widespread challenge to the fundamental beliefs and values of our social order. The matter goes beyond challenge to a rejection of the explicit and implicit systems of belief in our society, including the family, school, education, morality, work — in short, everything. Through a confluence of historical forces, the rebels of the new breed are not from one particular segment of our society, but from everywhere — from the lower, middle, and upper classes, and from among the advantaged as well as the disadvantaged.

Erikson's[1] term "identity crisis," aptly describes the current situation. Erikson[1] defines identity as: "The accrued confidence that the inner sameness and continuity are matched, by the sameness and continuity of one's meaning for others." This presupposes a shared framework of value systems within which one's meaning for others can be worked out. It is this framework which specifies the acceptable goals and purposes of life and defines the methods for attaining them. The framework specifies not only permissable behavior but defines the forms of deviation and rebellion. Erikson[1] saw the identity crisis as arising from a major discrepancy between the consciously or unconsciously chosen set of meanings and what is reflected back from the surroundings. The current identity crisis is characterized by the disintegration of the framework, because its basic premises no longer seem to be valid. What the adolescent sees, is an adult world which is failing to manage its own affairs. Problems abound and society, managed by adults, offers few solutions either on a personal or general social level. All classes in our society are affected by the continuing conflict in Vietnam and the unsolved problems of poverty and discrimination at home. In the background there is the militarization of science and all learning and the ever present threat of nuclear annihilation currently brought into sharp focus by the anti-ballistic missile controversy. Young people who have the advantages of education and skill in expressing themselves formulate their disillusionment in intellectual and philosophical terms. They elaborate the new philosophies of dissent. They "drop out" or become "activists" depending on a variety of factors including the particulars of personal history and family structure. Young people who have had fewer opportunities for education and less skill in expressing themselves *act out* their disillusionment without elaborating a philosophical justification. It is hardly possible at this point to catalogue the full range and variety of clinical syndromes which emerge. Some of the young people fit into the traditional diagnostic categories, others cross the traditional lines and exhibit the characteristics of different nosological entities at different times, and still others seem to require a new set of labels. It is not possible at this time to obtain a representative cross-sectional sampling of the range of reactions. In clinics, student health services, and other organized facilities, we see those who experience a greater degree of subjective distress. These adolescents are more apt to exhibit specific psychiatric syndromes including anxieties, phobias, depressions, and disorganization of thought. On the basis of the descriptions given by the young people who present themselves, similar symptoms appear to be widespread among those who do not seek professional help.

I would like to place particular stress on certain outcomes of the psychodynamic and developmental processes. One, is whether the adolescent has acquired a sense of competence to deal with the world and its problems and with himself. A second has to do with his expectations. Can anything be done about the situation in general or about his personal predicament? Can he, as an individual, or as a member of a group, expect to achieve anything worth struggling for? A third crucial element is the degree of cynicism and hopelessness. Cynicism and hopelessness are related to the capacity to organize and direct activities toward the achievement of goals. Elements of this sort must be added to our traditional composite picture of psychiatric syndromes and pschodynamic structures if we are

to deal effectively with our adolescents. Perhaps ultimately, by including such elements in our formulations, we will arrive at a more comprehensive classification system. The need for a new terminology is highlighted by the popularity of words like alienation, drop-outs, the uncommitted, and activists. These newly popular terms include a wide variety of individual patterns. Consider, for example, the adolescents who are labeled radicals or activists. They range from "The Young Radicals" described by Keniston[2] to the most militant campus and community groups. Keniston's[2] young radicals turned out to be a highly select group. He described them as well educated, highly organized and goal directed, conscientious, and constructive. They came, for the most part, from families of high educational attainment and grew up in an atmosphere which prized commitment to moral and ethical values. These young people were not rebelling, but following a radical path to the implementation of moral imperatives. They rejected some, though clearly not all, of our society's conventional standards for behavior. Their intellectual and educational advantages provided them with a philosophical framework, within which they could see their relationship to society, albeit in terms of changing the society. The level of expectation was high. They believed in their purposes and could envisage the possibility of achieving them. Thus, they were able to conduct their activities and sustain their efforts over an extended period in the face of disapproval and opposition. In describing this group of radicals, I have emphasized the element of expectation and competence to effect change, because there are many other young people who are similar in many respects, but differ in this one element. These are young people, who do not have a sense of competence and do not see themselves as being able to exert much practical influence. These young people tend to drop out to a greater or lesser degree. At the extreme there are those who see no line of connection between themselves and the rest of society. They give up all of the ordinary goals and aspirations and refuse to take part in the normal tasks and business of living. Though they may have an elaborate philosophical framework, a little probing beneath the surface reveals not only cynicism but a profound sense of despair. Some among this group of young people experience anxiety and depression to the point where they may seek therapy. Others maintain a facade of philosophical rationalizations and depend heavily on denial. They attempt to present a smiling "who cares, nothing is important or worthwhile" attitude. They find some support in congenial peer groups, to which they transfer much of their dependence and identifications. Although the peer groups are ostensibly oriented toward activism and social change, many of these adolescents find it difficult to sustain organized group activity. They are attracted to groups which espouse individualistic and impulsive actions and do not like political philosophies which call for disciplined activity in accordance with some general plan.

These characteristics are also reflected in personal relationships. These adolescents tend to be egocentric and exploitative. They avoid long term or permanent commitments and are more likely to be oriented towards immediate gratifications.

The composite picture, which I have been describing, applies to adolescents who come from the middle class and from the lower end of our economic and social system, as well as from the upper strata. Keniston's[2] young radicals come from families "most often characterized by considerable parental warmth, sympathy, understanding, and idealism," an item which is undoubtedly related to their sense of competence. The second group, which I have been describing did not, for the most part, enjoy the benefit of this favorable background factor. They, more frequently, came from homes characterized by marked internal frictions or disruption. The more affluent families provided adequate food, shelter, and education. However, at the lower end, these basic ingredients were in short supply. There was little in the experience of these deprived adolescents to instill a sense of competence or expectation that they could achieve personal goals or exert much influence on the world

around them. Generally speaking, they are not inclined to engage in philosophical elaborations or rationalizations. Their cynicism and hopelessness tend to be translated into action which is mainly rebellious and defiant. Parents and the larger society then become the targets for hostility which is expressed in a spectrum of behaviors ranging from minor infractions of the rules to serious anti-social activities. Drugs are widely used in all strata of our society nowadays, but all reports agree that the serious addictions are much more frequent among the deprived and disadvantaged. With reference to addiction, I am convinced that the sense of hopelessness about the real world is a major factor in turning adolescents toward retreat into the world of drugs. We must also include the despair and disillusionment which these adolescnts experience in the segment of the real world in which they live. Very few of these young people have the skills or even the inclination to verbalize their feelings, but they can be discerned and elicited if one takes the time and trouble.

We are living now in an era of explosive social movements. As psychiatrists, we are inclined to study the individual and his motivations. In many instances it is not difficult to demonstrate that individuals are driven by forces that arise out of their individual problems. We must guard against interpreting social movements in strictly individual terms. The validity of social movements is quite independent of the motivations which lead individuals to participate in them. Social movements may provide constructive channels through which originally negative motivations may serve socially useful ends.

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300 West End Avenue

Tax Deduction Urged For All Medical Costs

Full deductions of medical expenses from federal income taxes was proposed in legislation in the House of Representatives by Representative J. Herbert Burke (R, Florida). The bill (H.R. 14273) has the full support of the American Medical Association.

Burke told the House that his measure would "utilize the tax system rather than turning over administration of health care delivery to the federal bureaucracy as some are suggesting today."

Under present law, taxpayers may deduct as medical expenses only those payments in excess of 3 per cent of their adjusted gross income. In addition, a special deduction is allowed for a percentage of health insurance premiums.

The new bill removes the per cent limitation "and would permit any taxpayer to deduct the full amount of medical expenses and drug expenses paid for the medical care of the taxpayer, his spouse, and dependents," said Burke. It also would apply to deductions for medical bills paid for parents over 65.

Other AMA-sponsored legislation introduced in Congress calls for federal income tax credits (deductions from tax owed) for premiums paid for private health insurance with the percentage of the credit varying with income and including a subsidization for persons with low income. Burke noted that his bill would place all citizens in the same tax category as the aged were prior to enactment of the Medicare bill when all of their medical expenses were tax deductible.

—*AMA News,* October 20, 1969

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

December 21, 1969

A regular meeting of the Board of Trustees was held on December 21, 1969 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Lloyd A. Hamilton, M.D. . . . Adopted the following memorial resolution and authorized a contribution, in the amount of $50, to the Medical Student Loan Fund in memory of Dr. Hamilton:

Whereas, the late-lamented Lloyd A. Hamilton, M.D., was a faithful member of The Medical Society of New Jersey since 1936 and served three consecutive terms as a valued member of its Board of Trustees; and

Whereas, as a member of the State Board of Medical Examiners from 1964-1969, he rendered sustained service to the medical profession and the people of New Jersey; and

Whereas, in his practice and throughout his life he consistently exemplified the exalted qualities of mind and heart which typify the highest standards of professional and personal conduct; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey records profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting, and another copy, suitably prepared, be presented to his bereaved family.

Woman's Auxiliary . . . Approved a request of the President of the Woman's Auxiliary to present a five-minute report on the current year's activities to the opening session of the House of Delegates.

Conference Committee on the Control of Eye Medication . . . Noted, with approval, President Bertha's invitation to Reginald J. Raban, M.D., of Cherry Hill, to serve as a member of the Conference Committee on the Control of Eye Medication.

State Health Planning Council . . . Authorized President Bertha, in consultation with other members of the Board, to designate (upon invitation of the Council) MSNJ representatives to serve on the Medicaid Committee and the Health Care Costs Committee of the Council.

Cancer Chemotherapy . . . Approved cosponsorship, with no financial commitment, in cooperation with the New Jersey Regional Medical Program, the New Jersey College of Medicine and Dentistry, and the Cooper Hospital in Camden, of a course in cancer chemotherapy for New Jersey physicians, to be held on Thursdays from March 5 through April 30 at designated hospitals throughout New Jersey, New York City, and Philadelphia.

AMA—AMPAC Workshop . . . Designated Dr. Emanuel M. Satulsky of Elizabeth as MSNJ representative to the AMA-AMPAC Workshop, February 28 and March 1 in Washington, D.C. (One half the expenses will be paid by the AMA.)

AMA Conference of Medical Executives . . . Authorized the Executive Director (with expenses paid) to attend the AMA Conference for Senior Medical Executives to be held in Chicago, January 28 and 29.

Reception for Senators and Congressmen . . . Authorized Dr. John J. Bedrick of Bayonne and Dr. Louis K. Collins of Glassboro to represent MSNJ (with expenses paid) at the 33rd Annual Reception and Dinner for U.S. Senators and members of the House of Representatives (sponsored by the New Jersey Chamber of Commerce) to be held in Washington on February 5.

Woman's Auxiliary to Student American Medical Association . . . Authorized MSNJ's sustaining membership (at an annual fee of $15) of the WA/SAMA.

Conference of Presidents . . . Authorized the Spring Conference of Presidents and Presi-

dents-Elect for February 15, 1970 at the Executive Offices.

Joint Medicare Claims Inquiry Committee . . . Noted and concurred in the following: The fiscal intermediatry for Part B of Medicare (Prudential) has accepted MSNJ's proposal to establish a committee on inquiry to provide physicians who feel their fees have been arbitrarily reduced, or have basis for other dissatisfaction, with a forum for discussion. MSNJ representatives are: Nicholas A. Bertha, M.D., President; Emanuel M. Satulsky, M.D., President-Elect; Louis F. Albright, M.D., Donald T. Akey, M.D., and Mr. Richard I. Nevin, Executive Director.

Osteopaths to MSNJ Membership . . . Received the report of the Committee authorized by the 1969 House of Delegates to study the matter of receiving osteopaths as members of MSNJ, which stated that membership opinion will be polled by ballot early in January, for return by January 30.

Medical Education . . . Approved the report of the Committee on Medical Education, including the following recommendations:

1. That at the 1970 Annual Meeting there be a special student registration, and a distinctive student badge.

2. That The Medical Society of New Jersey provide transportation for the students of the two New Jersey medical schools upon assurance of the deans that there will be a sufficient number planning to attend.

3. That an invitation be extended to two representatives of each of the local chapters of SAMA to attend the 1970 Annual Meeting at MSNJ expense.

Medical Service Administration . . . Approved the following nominations for membership on the Board of Governors of Medical Service Administration: Irving P. Borsher, M.D.; Joseph I. Echikson, M.D.; Lloyd M. Felmy, Elton W. Lance, M.D.; Jerome C. Rothgesser, M.D.; Rudolph Schretzmann, M.D.; Edward W. Sprague, M.D.; Thomas J. White, M.D.

Compensation under Medicaid for Professionally Incorporated Physicians . . . Directed that whatever steps are necessary should be taken with the Department of Institutions and Agencies and the Board of Control to accomplish revocation of a decision that members of professional service corporations will be compensated only on the basis, and under their identification, as individual practitioners, so that professional service corporations may hereafter receive checks. If necessary to determine the legality of such payment, the Board of Control should be urged to appeal to the Attorney General for an opinion.

Board of Medical Examiners . . . Congratulated Dr. John F. Kustrup, Sr. upon his appointment to the State Board of Medical Examiners.

Emergency Physicians' College

Increasing patient loads in Emergency Departments across the country have underscored the need for a new type of physician — a specialist in emergencies: the Emergency Physician. So, the American College of Emergency Physicians was organized in August, 1968.

One of the main purposes of the College is to improve emergency services rendered to the patient. Other aims of the College are: to encourage and implement the training and continuing education of emergency physicians; to promote policy which preserves the integrity of private practice; to promote coordination of community emergency care facilities and personnel; to advance the ethical standards of the private practice of Emergency Medicine and Surgery.

If interested, write to the College at 120 West Saginaw Street, East Lansing, Michigan, or to the representative in our state, Dr. Herbert Butler, Underwood Hospital, Woodbury.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during December 1969.

	1969 December	1968 December
Aseptic Meningitis	20	11
Primary Encephalitis	1	1
Post-Infectious Encephalitis	0	0
Hepatitis: Total	234	155
Infectious	194	135
Serum	40	20
Malaria	10	2
Military	8	2
Civilian	2	0
Meningococcal Meningitis	5	14
Mumps	251	343
German Measles	21	33
Measles	94	33
Salmonella	26	46
Shigella	82	23

Measles

Measles in New Jersey has increased over the past two months. Ninety cases of measles were reported to the New Jersey State Health Department during November 1969, and 99 cases through the fourth week of December. These figures are contrasted to 45 cases of measles during October 1969, 32 cases in November 1968, and 46 cases in December, 1968. Localized clusters of cases have occurred in Atlantic City, Lakewood, Camden, New Brunswick, Mays Landing, and Manalapan, Mount Olive, Howell, and Burlington Townships. A city-wide measles immunization program has been conducted in Atlantic City with the administration of approximately 1400 doses of vaccine. Township-wide measles' programs have been carried out in Manalapan, Mount Olive, and Burlington Townships with 250-325 children immunized in each. Additional state-sponsored vaccination programs are planned for early 1970. The Acute Communicable Disease Control Program is anxious to have cases of measles reported promptly so that immunization programs can be undertaken at an early date in order to avert unnecessary morbidity.

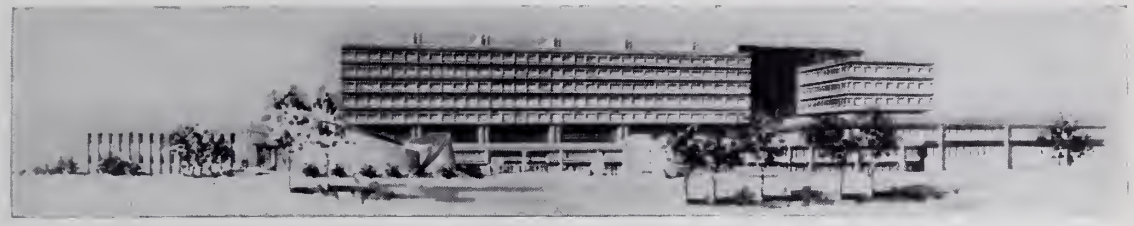
Antibiotics in Acute Salmonella Gastroenteritis

Gastroenteritis produced by *Salmonella* species is generally a mild and self-limited illness. Antibiotics do *not* alter the clinical course of uncomplicated salmonella gastroenteritis. Reserve antibiotics for the treatment of systemic infections with bacteremia and/or metastatic sites of infection. Despite the mild nature of the clinical illness, antibiotics have often been used by physicians in an attempt to reduce the period of fecal excretion of salmonellae during the post convalescent period, since these patients represent a potential source of infection to others.

In a recent publication (*New Engl.J.Med.* 281:636, Sept. 18, 1969), Aserkoff and Bennett found that antibiotic therapy during acute Salmonellosis with ampicillin, chloramphenicol, or other agents *prolonged* rather than shortened the period of post convalescent excretion of salmonellae. These investigators found that 65 per cent of antibiotic treated patients had stools positive for *Salmonella typhimurium* 12 days after exposure, and 27 per cent were positive at 31 days. In a second group who acquired their infection in the same foodborne outbreak but who did *not* receive antibiotics, only 42 per cent and 11 per cent had stools positive for *Salmonella typhimurium* at 12 and 31 days respectively. It was also noted that antibiotics favored the *in vivo* development of antibiotic resistance by the infecting organisms. Among the antibiotic treated group, 10 per cent of the salmonella isolates were resistant to one or more antibiotics, while no resistant strains were isolated from the untreated group of patients. The authors conclude that "antibiotic therapy increases the opportunity not only for person-to-person spread of infection, but also for dissemination of resistant organisms."

204th Annual Meeting

May 16-19, 1970



News From NJCMD

Two-thirds of those who suffer fatal coronary attacks in this country never reach a hospital alive. If a patient gets to a hospital without a specialized coronary care unit, his chance of survival is 65 per cent. If he reaches a C.C.U., his chances increase to 83 per cent. New Jersey College of Medicine and Dentistry is deeply involved in a demonstration project designed to bridge this vital survival gap and thus raise the victim's chances by actually bringing the CCU to the patient, at the scene of the attack. Certainly, many deaths due to acute MI could be prevented if immediate specialized medical care could be administered. But how do you provide coronary care to a patient who suffers an attack on a busy street corner, in a subway, a theatre, his home, or place of business? You go *to* the victim with a Mobile Coronary Care Unit. NJCMD/Martland Hospital is providing national leadership in just such a project, the only one in the state and one of just two functioning units in the nation.

The emergency medical service system for heart victims was initiated by Dr. J. Frank Pantridge, of Royal Victoria Hospital in Belfast, Ireland. He pioneered the concept of the Mobile CCU (also called a coronary ambulance) with his Belfast unit in 1966. Dr. Mortimer L. Schwartz, Professor of Medicine and Director of Clinical Cardiology at NJCMD, has discussed the program with Dr. Pantridge, and set the wheels in motion to bring the Mobile CCU to Martland Hospital.

The mobile CCU began operation on July 10, 1969, bringing immediate treatment to the heart victim rather than losing crucial time bringing the patient to the treatment. The program is now under study with specialized equipment, purchased through a State Department of Health grant. There is no single Mobile CCU, although one is on order. Equipment is utilized presently for eight hours on week days in one of Martland's regular ambulances. The next step (if more support is forthcoming) will be to expand the program to 24 hours a day, seven days a week.

The Mobile Coronary Care Unit is equipped with battery powered monitor-defibrillator, EKG, and suction apparatus, in addition to intravenous equipment, drugs, oxygen, and other supplies. Three cardiac residents ride on each "run" of the rig, their first priority being stabilization of the patient's condition before he is placed in the unit for transport to the hospital. When necessary, treatment is provided *en route*. Thus, the unit provides the patient with the same equipment, personnel and knowledge available in Martland Hospital's Coronary Care Unit.

In addition to preparing for around-the-clock service, the College hopes for further backing to improve communications for the program, including direct radio contact between the Mobile CCU personnel who load the special CCU. Presently, calls for the Mobile CCU come through the Newark Police Emergency Squad, which filters emergency calls and reports possible coronaries to the Martland switchboard. There, the operator calls the Mobile CCU personnel who load the special equipment and are on the way moments later. The College also hopes to expand the service area beyond its present physical boundaries, which are the borders of Newark. This big city encompasses over 24 square miles with some 400 miles of streets and highways. That patient could be miles from the start of the run, yet the average time between receipt of that "hot call" at Martland and the arrival

of the Mobile CCU at the patient's side is 16.6 minutes! Dr. Schwartz and his project team are working on *that,* too! He anticipates cutting that time in half.

Ideally, says Dr. Schwartz, a patient who feels pain in his chest or sudden shortness of breath. should *immediately* call his own physician. He, in turn, would alert the Mobile CCU by calling Martland Hospital, then go to his patient. The physician could administer emergency procedures (cardio-pulmonary resuscitation, drugs, or whatever is indicated) until the Mobile CCU arrives, if it isn't already there on his arrival. Thus, constant care and medical supervision is available to the stricken patient. Once the trained team and equipment reach the patient, he is in fact in a coronary care unit, and he remains in one from that point on.

Further expansion of emergency medical care for acute MI victims has been provided over the past five years by NJCMD/Martland through training symposia on cardio-pulmonary resuscitation. The program has just completed its 50th course. Over a thousand New Jersey physicians and nurses have been instructed in these lifesaving emergency technics. The program, organized by Dr. Schwartz, is conducted ten times a year, and includes lectures, demonstrations, and supervised practice in external cardiac compression, assisted pulmonary ventilation, endotracheal intubation, and practice in defibrillation methods. These dedicated health personnel are thus well equipped to care for patients in those first critical moments of a heart attack.

The importance of these demonstration projects is obvious. Hospitals and ambulance squads not only in New Jersey but across the nation are watching with great interest, as NJCMD undertakes the leadership in demonstrating pilot programs for better health care.

German Measles Vaccine Now Available

The new Rubelogen® has just been made available by Parke, Davis & Company. The vaccine is recommended for all children between the ages of one year and up to adolescence, especially those in kindergarten and early elementary grades, but routine immunization of adolescent and adult females is not recommended.

Parke Davis conducted massive clinical trials of the rubella vaccine to obtain the data necessary for government approval. I. W. McLean, M.D., and Dr. Robert G. Brackett, both of Parke-Davis, served as medical and scientific monitors for these studies which were the largest ever conducted by the company. More than 20,000 children were given the vaccine, in 14 separate clinical studies, conducted over a nine-month period in 1969.

Dr. Joseph F. Sadusk, Jr., of the Parke-Davis department of Medical Affairs, said the trials proved that the vaccine provided effective protection against German measles in from 96 to 100 per cent of those immunized. While the disease is usually mild, when this is contracted by women during pregnancy, it frequently causes abnormalities in, or even death of, the fetus. In 1964, 20,000 children were born with severe defects and at least that many stillbirths or miscarriages occurred. Almost 100 per cent of the children born to women who had German measles during the first two months of pregnancy have serious birth defects. Significant levels of protection begin about three weeks following use of the vaccine. Rubelogen® is available in a package of five single-dose vials of the vaccine with a multiple-dose vial of diluent.

Patronize Our Advertisers
They Merit Your Support

Physical Fitness----Before Fifty!

(By George Sheehan, M.D.)*

At Cape Kennedy last July, Apollo 11 entered a countdown that was to catapult us into the space age. At the same time, at the New York City Coliseum the American Medical Association inched into the 20th Century.

The convention of "the last of the pushcart industries" opened with a stormy session during which a hospital psychiatric resident, Richard Kunnes, asked for AMA's dissolution. The following day the Association started a long-range plan to fulfill Kunnes' request.

It began to talk about health. Moderator of the panel of experts on fitness and aging was Boston physician Frank Foster. He said the panel would "examine the problems that spring from our skill."

Freely translated this meant, "We are wasting *cum laude* students in what Thornton Wilder called 'the business of patch up, repair, and shore up.' Prevention and health is where our energies should be."

The leadoff speaker was Lawrence Lamb, a cardiologist with the aerospace program in Houston. Dr. Lamb, a trim 42-year-old who looks to be in his early 30's, said that Americans didn't know what old age is. "Most of the things we attribute to age," he said, "are due to disease. Most of it cardiovascular disease, the most important disease process in the history of mankind."

Prevention of these circulatory disorders of the heart, brain and kidney, according to Lamb, demands a fitness program of the broadest possible scope. It would include exercise, diet, weight reduction, good health habits, and attention to the mental and physical environment.

"At 50," wrote Plato, "prepare for abstinence." Lamb would have us start in our teens. Studies of the hearts of American soldiers killed in Vietnam (average 22 years old) showed that 70 per cent already had beginning hardening of the arteries.

Lamb spent little time on heart transplants ("theatrics," he called them) which he considered of no present importance and little prospect for the future. On the Barry Gray show that night he reported the following food intake that day. Coffee and toast for breakfast ("Americans should get used to a very light breakfast"); no lunch; and a piece of chicken, a salad, and a custard ("I indulged myself") for dinner.

The case he presented for exercise was a strong one. He listed at least five benefits: (1) Increased blood vessels (detours) in the heart muscle; (2) Stronger heart muscle; (3) Lower blood pressure; (4) Improvement of the other arteries in the body; and (5) Improvement of the blood factors that enter into hardening of the arteries. In the key consideration of weight control, he said that exercise and diet were inseparable.

For Lamb, the most discouraging finding in the "normal" American male (Lamb suggests he be called the average degenerating American) is his body weight. Studies of the astronauts have convinced him that our ideas about normal body weight have to be drastically revised.

The candidates for the astronaut program had a lean body weight (measured in the percentage of fat in the body) which was one-third less than Air Force personnel in the same age group. Their cholesterol was also 30 per cent lower than the Air Force standard. Lamb attributed these findings to the training the men had voluntarily imposed on themselves in competing for the positions.

One could visualize a return to Hippocrates who listed five other ways to health before he came to drugs. He reserved surgery for a last resort. Medicine was coming full circle. Once again the physician would be a teacher, the patient the pupil, the subject health.

* Reprinted with permission from the Red Bank (N.J.) *Daily Register* as one of Dr. Sheehan's columns, "The Innocent Bystander."

This has been long in coming. Only a month ago, at the American College of Cardiology, Dr. William Kannel, the director of the Framingham study on heart disease and stroke, had called for a "new breed of doctor," one who thinks in terms of prevention rather than in terms of crisis. "The whole system is backwards," Kannel said. "Until American medicine gets away from its preoccupation with the treatment of acute illness, no real inroads are going to be made."

But if we have immature physicians we also have immature patients. Not content with expecting health to be sold or conferred, they ask (and receive) personal attention unnecessary and inappropriate when doctors are equally competent and overworked. An example of this Victorian medicine occurred recently in a local hospital when four obstetricians spent the night each watching one private patient.

It should be instructive that Lamb, the physician of the future, and the astronaut, the man of the future, are products of military medicine, the most maligned form of medical practice because of its impersonal approach. But also the most efficient (the individual health record must eventually have its counterpart in civilian life.) And the most interested in health and preventive medicine.

We astronauts of this "Spaceship Earth" could have no better models than the men of the Apollo program. Men of faith like Frank Borman, who also have 11 per cent body fat, resting pulses in the 50s, and a brand of health that will allow them to participate mentally and physically in the adventures middle age and the advancing years of wisdom have in store for them.

204th Annual Meeting
May 16-19, 1970
Chalfonte-Haddon Hall
Atlantic City

Proposed Ghetto Medical Corps

Writing in the February 1970 *Resident and Staff Physician,* Charles A. Regan, M.D., (Director of Medical Service at Harlem Hospital Center, NYCS) says that not enough physicians practice in poor neighborhoods of our larger cities. Yet the medical needs of the people in these areas are urgent—and must be met. How can we do it? One way would be for the federal government to establish a special medical corps to serve these areas—and to accept such service as a substitute for military duty.

"This thought occurred to me when it was recently suggested that two proposed neighborhood health centers come under the wings of Harlem Hospital, and that Harlem serve as the back-up hospital and possibly be responsible for the supervision of the care tendered and the recruitment of the staff. I have also been asked to enlist staff for another center already in operation. The two proposed centers have had their capital budgets approved, architectural drawings completed, equipment lists made up, and have every expectation of operational funds being approved. The planning has been by architects and public health officials who have little knowledge of the problems of professional and technical staffing, of the delivery of care, and of supplying supervision to assure the competence of that care.

"There are few physicians in the areas to be covered and most of them are already quite busy on the staff of this hospital or in private practice. Recruitment of house staff for outpatient work as a major part of their training is in its infancy, and it is doubtful if the large numbers required could be obtained and the necessary supervision given. One answer to the dilemma of professional recruitment would be to establish this as a form of national service in lieu of military service. Well-trained people, either at the end of their training program or after internship and one year of residency, would provide the staff for these health centers."

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY—Richard Helfant, M.D., Peter Bent Brigham Hospital, Boston, Massachusetts 02115. NYU—Bellevue 1963. Board eligible. Cardiac catherization laboratory in hospital. Available July, 1970.

Edgar Lichsten, M.D., 300 Kensington Avenue, New Britain, Connecticut 06050. NYU (Downstate) 1961. Board certified in Internal Medicine. Full-time position in cardiology. Available January 1970.

DERMATOLOGY—Frederic R. Rothman, M.D., 413 College Parkway, Rockville, Maryland 20850. Michigan, 1964. Board certified. Partnership or group. Available July 1970.

David J. Tuckman, M.D., U.S. Darnall Army Hospital, Fort Hood, Texas 76544. Hahnemann, 1964. Board certified. Group, partnership, or solo. Available July 1970.

GENERAL—Richard D. Hasz, M.D., 1535 Sixth Street, Waynesburg, Pennsylvania 15370. University of Buffalo 1963. Board eligible. Solo or partnership. Available August 1970.

Robert J. Ailes, M.D., 72 Van Allen Road, Glen Rock, New Jersey 07452. Western Reserve 1964. Group, hospital, or industrial (part-time only) Available.

INTERNAL MEDICINE—Chaim Charytan, M.D., 109 Eastridge Drive, San Antonio, Texas 78227. Einstein College of Medicine, 1964. Board eligible. Subspecialty, nephrology. Solo, partnership, group, or institution. Available July 1970.

Noel I. Robin, M.D., 19 Lake Shore Court, Brighton, Massachusetts 02135. Downstate Medical Center (NYU), 1965 Board eligible. Subspecialty, endocrinology. Group (teaching hospital and medical school affiliation). Available July 1970.

Barry R. Zitomer, M.D., 14501A DelAmo Street, Santa Ana, California 92705. Pennsylvania 1963. Board eligible. Partnership or group. Available July 1970.

Stephen H. Jacobs, M.D., Quarters 8620, Fort Lewis, Washington 98433. Georgetown 1964. Board eligible. Group or partnership (preferably Bergen County). Available August 1970.

Aaron Weisberg, M.D., 1060 Ocean Avenue, Brooklyn, New York 11226. Cincinnati, 1939. Board Certified. Group or partnership. Available January 1970.

Allen Chinitz, M.D., 650 West 64th Drive, Hialeah, Florida 33012. NYU (Downstate) 1961. Board eligible. Solo, partnership, or group. Available September 1970.

Panagis Kokolis, M.D., 1602-D South 30th Street, Philadelphia, Pennsylvania. University of Athens (Greece) 1957. Board eligible. Group, partnership, or solo. Available January 1970.

NEUROLOGY—Steven L. Eisen, M.D., 165 West End Avenue, New York 10023. Albany 1966. Board eligible. Solo, partnership, or group. Available June 1970.

Harvey H. Kornblit, M.D., 1906 Wyndale, Houston, Texas 77025. Zurich (Switzerland) 1956. Solo, associate (full or part-time), or group. Available.

OBSTETRICS AND GYNECOLOGY—Stan P. Smith, M.D., 3702A Spruce Street, Dover, Delaware 19901. Temple, 1964. Board eligible. Partnership. Available September 1970.

Michael Mandell, M.D., 296 Duncan Court, Loring AFB, Limestone, Maine 04750. Albert Einstein 1963. Board eligible. Group or partnership. Available July 1970.

OTOLARYNGOLOGY—Robert P. Plotkin, M.D., 145 Fourth Avenue, Apt. 4E, New York, New York 10003. Wisconsin, 1962. Board eligible. Associate. Available July 1970.

Deborah Chernock (Block), M.D., 536 Wyndham Road, Teaneck, New Jersey 07666. University of Chicago, 1966. Associate or group. Available.

Phil Brunner, M.D., 5 Clipper Road, Palos Verdes Peninsula, California 90274. NYU (Downstate) 1965. Board eligible. Group. Available August 1970.

PHYSICAL MEDICINE—Peter T. Han, M.D., VA Hospital, Department of PMRS, Brooklyn, New York 11217. Shanghai Tung Teh 1948. Group or hospital. Available January 1970.

RADIOLOGY—Santos F. Delgado, M.D., 2201 Dublin Road, Pulaski, Virginia 24301. Santiago (Spain) 1953. Board certified. Group, partnership, or association. Available spring 1970.

SURGERY—Ali Ghazi, M.D., 195 Adams Street, Brooklyn, New York 11201. University of Teheran, 1958. Board eligible. Associate or group. Available.

Ignacio M. Cruz, M.D., 4038 58th Street (Woodside) New York, New York 11377. University of Santo Tomas, 1959. Board certified. Group, partnership, or full time. Available.

Francisco D. Avellana, M.D., 2670 Montana Avenue, Apt. 8 Cincinnati, Ohio 45211. University of Manila 1959. Board eligible. Group partnership or solo. Available July 1970.

Richard H. Unger, M.D., 106th General Hospital, APO San Francisco 96503. Seton Hall 1963. Board eligible. Group, associate, solo. Available August 1970.

Manuel S. Garcia, M.D., 903 Hensley Heights, Man, West Virginia 25635. Santo Tomas (Manila) 1957. Board eligible. Solo or associate. Available December 1969.

OBITUARIES

Dr. Peter J. LaBarba

Though he was only 60 years old at the time, Dr. LaBarba's life came to an end on December 3, 1969. A well-known Bergen County practitioner, he was in the class of 1934 at the former Long Island College of Medicine. He practiced in Hasbrouck Heights and was affiliated with the South Bergen Hospital in that town, as well as with the Hackensack Hospital where he was an Adjunct Attending Physician on the General Practice staff.

Dr. Roland J. Lynch

Long known for his pioneer work in developing a modern psychiatric institution at the Hudson County Mental Hospital (now called Meadowview), Roland J. Lynch, M.D., died on Thanksgiving Day 1969, at the age of 83. Dr. Lynch was a 1914 graduate of the Long Island College of Medicine. After an internship at St. Mary's Hospital in Hoboken, he did two years of general practice and then accepted a residency at the Hudson County Hospital for Mental Diseases in 1919. He advanced through all positions in the staff, becoming medical director at Secaucus in 1942, in which capacity he served until his retirement in 1955.

Dr. Charles W. Potter

One of the true exemplars of the "beloved physician," Charles W. Potter, M.D., died on December 30, 1969, at the age of 67. Born in Canada, he got his M.D. from the University of Toronto in 1927 and came to the Jersey City Medical Center for internship. He liked our state, became a ASA citizen, and a citizen of New Jersey too. He was active in the work of the First Presbyterian Church of Washington, New Jersey, and was a past president of the Warren County Medical Society. He was a vigorous and helpful participant in all phases of community life in that corner of the state.

Dr. A. Lincoln Sherk

At the age of 73, A. Lincoln Sherk, M.D., one of South Jersey's best known practitioners, died on January 4, 1970. A 1923 graduate of Jefferson Medical College, he was a general practitioner serving the people of Camden County for almost half a century. He was well known for his studies in botany and mineralogy, and was a director of the Camden Bank and Trust Company.

Dr. Peter A. Simeone

November 18, 1969 saw the death of Peter A. Simeone, M.D., a well-known Jersey City family doctor. Born in 1902, Dr. Simeone was a Bellevue graduate, class of 1927. He was active in civic and professional affairs in the northeastern part of New Jersey and in committee work for the Hudson County Medical Society.

Dr. A. Marshall Smith

Middlesex County lost one of its most useful citizens on December 20, 1969 with the death that day of A. Marshall Smith, M.D. He was chief of surgery at the Middlesex General Hospital, and a past president of the Middlesex County Medical Society. Dr. Smith was active in the Boy Scouts, in his church, in the Visiting Nurses' Association, and was commodore of the Abenaski Yacht Club in Maine. He was the director of civil defense in Middlesex County during World War II. The national symbol for the Civil Defense Agency is the one that Dr. Smith originally designed as the county defense emblem. Dr. Smith was 68 years old at the time of his death.

Dr. Stuart A. Weiss

A promising radiologic career was cut short on November 24, 1969. with the death that day of Stuart Arthur Weiss, M.D. who was only 44 years old at the time of his passing. He earned his M.D. at Bellevue in 1949, one of the youngest in his class. He did graduate work in roentgenology, and received his board diploma in that specialty in 1967. The same year he was elected to the American College of Radiology. He was identified with the Monmouth Medical Center, and was active in the affairs of our Monmouth County Medical Society.

ANNOUNCEMENTS

Pulmonary Physiology Course

During the five day period beginning March 2, an intensive course in pulmonary and respiratory physiology will be offered by the University of Pennsylvania School of Medicine. The fee is $125 and attendance is limited. The program includes respiratory problems in anesthesia, pulmonary surfactants, physiology of thoracotomy and demonstrations of hyperbaric oxygenation. Inquiries should be directed to the Department of Graduate Education, 288 Medical Laboratories Building, Philadelphia, Pennsylvania 19104.

Clinical Application Of Basic Sciences

The basic science and clinical application series offered by the Burlington County Memorial Hospital will hold its March meetings on four Thursdays at 3:30 p.m. in the T. J. Summey Building at the hospital. AAGP credits 1½ units per session.

March 5	Diagnosis and Treatment of Lymphomatous Disease
March 12	Recent Advances in the Treatment of Leukemia
March 19	Chemotherapy of Disseminated Solid Tumors
March 26	Differential Diagnosis of the Polycythemic States

For further information, please write to the Director of Medical Education (Dr. J. R. Wolgamot), Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly.

Meeting On Marriage

Under the pessimistic title of "Marriage: Death of a Relationship," our state's Neuropsychiatric Association and Psychological Association will hold a joint meeting at the Holiday Inn in East Orange on Friday, March 6. Dinner is at 6 p.m. and the scientific program begins at 8 p.m. All readers of this *Journal* are invited. For further details, please write to Mary Ann Bartusis, M.D., 383 West State Street, Trenton 08618.

Anesthesia Seminar

You are welcome to attend the 11th Annual Anesthesia Seminar, to be held this year on Saturday, March 7, at the Cherry Hill Inn in Cherry Hill, near Camden. This is an all day meeting, the first paper on pediatric anesthesia being given at 9:30 a.m. The program closes with an informal discussion by a panel of experts. For more information write to the New Jersey Society of Anesthesiologists, 180 East 21st Street, Paterson.

Cystic Fibrosis Seminar

Physicians, nurses, and physical therapists are invited to attend and participate in a seminar on cystic fibrosis and other pulmonary diseases in children, to be held at the Monmouth Medical Center in Long Branch on March 12. A prominent faculty has been recruited. This seminar is sponsored by the Delaware Valley Regional Medical Program, the State Department of Health, and the pediatric services of the Monmouth Medical Center. The seminar begins at 12:30 p.m.

Emotional Problems In Office Practice

Columbia University announces a practical set of seminars concerned with the emotional problems in office practice. Each program consists of ten two hour seminars, from noon until 2 p.m. The first is on April 1 through June 3. This is repeated starting October 7. The cost is $50. For information write to the Associate Dean at 630 West 168th Street, New York 10032.

Contact Lens Seminar

All day on Saturday, May 9, the New York Eye and Ear Infirmary will hold its annual contact lens seminar. The fee is $50, which includes luncheon and a reception. Residents in ophthalmology may attend for a fee of $20. Details will be supplied by the Registrar of the Post Graduate Institute, New York Eye and Ear Infirmary, 310 East 14th Street, New York 10003.

Physicians Trip To Israel

The American Physicians Fellowship offers a tour of Asia Minor in conjunction with the Eighth World Assembly of the Israel Medical Association, to be held in Jerusalem, Haifa, and Tel-Aviv, May 18 to May 29. The tour, the 13th of its kind, leaves New York on May 16 and returns on May 31. The cost is $950. Further information is obtained from Dr. Manuel M. Glazier, American Physicians Fellowship, 1622 Beacon Street. Brookline, Mass.

Medical Trip to Japan and Hong Kong

For only $898 per person you can fly to Tokyo and Hong Kong and back during July 1970. This is a trip sponsored by the Bergen County Medical Society, and all members of MSNJ are eligible to participate. Included is first class service on the plane—and this means really first class—and superior hotel accommodations in both Tokyo and Hong Kong, with breakfast and dinner every day. You won't even have to tip for baggage help, or at mealtime. There will be medical symposia each morning, with the afternoon free.

You can even pick up an outside trip to Osaka to visit Expo-70, the first world exposition held in the Orient. Space is limited, and is on a first come basis. If you are interested get in touch with the Bergen County Medical Society, 215 Union Street, Hackensack, New Jersey 07601.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

February

11 **Academy of Medicine of New Jersey**
Rutgers—Student Center
Newark
Symposium on Immunology

11 **Middlesex County Medical Society**

11 **Ocean County Medical Society**

11 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

11 **St. Michael's Medical Center**
Newark
Physical Diagnosis Reviewed

12 **Burlington County Memorial Hospital**
Mount Holly
Renal Transplantation

14 **Academy of Medicine of New Jersey**
Section on Anesthesiology
St. Barnabas Medical Center
Livingston
"Pulmonary and Arterial Sampling"

17 **Warren County Medical Society**

17 **Academy of Medicine of New Jersey**
Newcomb Hospital
Vineland
Symposium on Resuscitation Procedures

18 **Academy of Medicine of New Jersey**
Section on Eye, Ear, Nose, and Throat
St. Barnabas Medical Center
Livingston
Anesthesia Problems in Ocular Surgery

18 **St. Michael's Medical Center**
Newark
The Kidney: Commonly Used Tests; Applications for Management

19 **Burlington County Memorial Hospital**
Mount Holly
Renal Transplantation: Indications and Technics

19 **Gloucester County Medical Society**

19 **Morris County Medical Society**

26 **Academy of Medicine of New Jersey**
Section on Radiology
Bloomfield
Interesting X-rays of the Month

26 **Academy of Medicine of New Jersey**
Section on Anesthesiology

Orange Memorial Hospital
Orange
"Epidural Block Anesthesia"

26 **Burlington County Memorial Hospital**
Mount Holly
Computers in Medicine

March

3 **Hudson County Medical Society**

5 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Treatment of Lymphomatous Disease

6 **New Jersey Academy of Medicine and New Jersey Society of Thoracic Surgery**
Glen Ridge Country Club
Glen Ridge
"The Chest Wall"

7 **New Jersey Society of Anesthesiologists**
Cherry Hill Inn
Cherry Hill
11th Postgraduate Seminar

10 **Academy of Medicine of New Jersey**
Section on Dermatology and
New Jersey Dermatological Society
Paterson General Hospital
Paterson

10 **Bergen County Medical Society**

11 **Holy Name Hospital**
Teaneck
"Dietary Management of Kidney Disease"

11 **Middlesex County Medical Society**

11 **Ocean County Medical Society**

11 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

11 **St. Michael's Medical Center**
Newark
Endocrine Review

12 **Academy of Medicine of New Jersey**
John E. Runnells Hospital
Berkeley Heights
Symposium: Coronary Care Units

12 **Burlington County Memorial Hospital**
Mount Holly
Recent Advances in the Treatment of Leukemia

18 **Academy of Medicine of New Jersey**
Colloquium on Suicide

19 **Burlington County Memorial Hospital**
Mount Holly
Chemotherapy of Disseminated Solid Tumors

19 **Academy of Medicine of New Jersey**
Somerset Hospital
Somerville
Symposium: Hypnosis in Medicine

19 **Gloucester County Medical Society**

19 **Morris County Medical Society**

20 **Academy of Medicine of New Jersey**
Cooper Hospital
Camden
Symposium: Pulmonary Problems

21 **Academy of Medicine of New Jersey**
Section on Anesthesiology
Orange Memorial Hospital
Orange
"Therapeutic Block for Pain of Carcinoma"

23 **Academy of Medicine of New Jersey**
North Hudson Hospital
Weehawken
Symposium on Emergency Room Care

24 **Hunterdon County Medical Society**

26 **Academy of Medicine of New Jersey**
Section on Radiology
Bloomfield
Interesting X-rays of the Month

26 **Burlington County Memorial Hospital**
Mount Holly
Differential Diagnosis of the Polycythemic States

30 **Cape May County Medical Society**

April

2 **Burlington County Memorial Hospital**
Mount Holly
Management of Painful Syndromes of the Head and Neck

2 **St. Joseph's Hospital**
Paterson
Program on Stroke

8 **Academy of Medicine of New Jersey**
Hoffmann-LaRoche
Nutley
Symposium: "Surgical Management of the Mind"

8 **Middlesex County Medical Society**

8 **Ocean County Medical Society**

8 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

9 **Burlington County Memorial Hospital**
Mount Holly
Rheumatoid Arthritis: Current Concepts of Differential Diagnosis and Management

10 **Academy of Medicine of New Jersey**
Cooper Hospital
Camden
Symposium: Hypnosis in Medicine

10 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Symposium: Pulmonary Problems

14 **Bergen County Medical Society**

14 **Cumberland County Medical Society**

15 **Academy of Medicine of New Jersey**
Section on Dentistry
Veterans Administration Hospital
East Orange
Symposium: "Preventive Dentistry"

16 **Burlington County Memorial Hospital**
Mount Holly
Fits, Faints, and Funny Turns

16 **Gloucester County Medical Society**

16 **Morris County Medical Society**

21 **Warren County Medical Society**

23 **Burlington County Memorial Hospital**
Mount Holly
The Significance of Hypoglycemia

30 **Burlington County Memorial Hospital**
Mount Holly
Definition, Etiology, and Classification of Congestive Heart Failure; The Pathology and Dynamics of the Failing Heart

May

5 **Hudson County Medical Society**

6 **New Jersey Heart Association**
Rutgers
New Brunswick
Myocardial Infarction and Drug Therapy

6 **St. Michael's Medical Center**
Newark
Controversies in Management of Heart Problems

7 **Burlington County Memorial Hospital**
Mount Holly
Evaluation and Medical Management of Acute and Chronic Heart Failure

12 **Bergen County Medical Society**

13 **Ocean County Medical Society**

13 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

14 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Heart Disease and Selection of Patients for Heart Transplant

16-19 **The Medical Society of New Jersey**
Chalfonte-Haddon Hall
Atlantic City
Annual Meeting

21 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Management of Pulmonary Embolic Disease

21 **Gloucester County Medical Society**

21 **Morris County Medical Society**

25 **Cape May County Medical Society**

27 **Academy of Medicine of New Jersey**
Annual Awards Dinner

27 **Middlesex County Medical Society**

June

3 **New Jersey Gastroenterological Society**
Newark
Annual Meeting

9 **Bergen County Medical Society**

9 **Cumberland County Medical Society**

10 **Middlesex County Medical Society**

10 **Ocean County Medical Society**

10 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

16 **Warren County Medical Society**

18 **Morris County Medical Society**

BOOK REVIEWS

A Synopsis of Contemporary Psychiatry. George A. Ulett, M.D. and D. W. Goodrich, M.D., St. Louis, 1969, Mosby. Ed. 4. Pp. 340. Price $9.50

Here is a manual built to fit into the side pocket of a clinic coat. If $9.50 seems a bit high for a 340 page book of these dimensions, remember that everything else has gone up in price, too. The text is aimed at everybody except psychiatrists, but it won't do them any harm to be familiar with this book. The goal of the writing is brevity and eclecticism, not depth or background. Within the limits of these criteria, the text includes material on electro-encephalography, intelligence testing, the role of the psychiatric social worker, hydrotherapy (though the authors concede that this is a dead duck by now), military psychiatry, court room testimony, community mental health, group therapy, suicide anticipation, and domestic relations problems, as well as the usual spectrum of material on the psychoses and neuroses. This is a useful pocketbook for nurses, social workers, interns, psychologists, and other professional and subprofessional people whose work overlaps that of the psychiatrist. To each chapter is appended an excellent bibliography, permitting the reader to dip deeper into phases of the subject that are interesting and important to him.

L. J. Barone, M.D.

Modern Treatment: (Volume 6, #3), **Treatment of Thyroid Disease,** James A. Pittman, Jr., M.D., Editor; **Treatment of Vertigo,** Myron W. Frederic, M.D., Wallace Rubin, M.D., and Robert J. Wolfson, M.D., New York, 1969. Hoeber Medical Division, Harper and Row. Pp. 188. ($16 per year by subscription)

Clarity, brevity, and economy are the hallmarks of this paperback issue of the May 1969 series "Modern Treatment" published by the Hoeber Medical Division of Harper and Row. The volume contains two monographs, one on the treatment of thyroid disease, the second on the treatment of vertigo. Each is covered in considerable detail. The paper on thyroid disease begins with an excellent review of the physiology of the gland and a discussion of diagnostic tests. Diagrams clearly indicate the metabolism of the thyroid hormones and correlate this with thyroid function tests. This is followed by careful consideration of each of the individual dysfunctions of the thyroid gland, beginning with hypothyroidism and including such topics as thyroiditis, hyperthyroidism, and Graves' Disease. Included is a discussion of thyroid nodules and cancer. Practical suggestions are made for the treatment of each thyroid condition and its complications with a detailed presentation of drugs, dosage, and surgical procedures.

The monograph on vertigo is equally concise and detailed in considering this common symptom. It covers Meniere's Disease, includes a description of the pathology and of the appropriate diagnostic tests. Modern drugs such as betahastine hydrochloride are described, as well as a consideration of dietary and other forms of therapy. There is a brief description of surgical procedures used in Meniere's Disease. The role of arterial disease, tumors, otolaryngologic conditions are likewise considered with some detailed descriptions of conditions such as otodystrophies, including neurofibromatosis and osteogenesis imperfecta.

Both sections of this outstanding treatise are excellent and can be recommended to any physician concerned either with thyroid disorders or disturbances in equilibrium. The publishers are to be commended for their ability to provide, at a little over $2.00 a copy, such a fine contribution to medical literature.

Rowland D. Goodman, II, M.D.

Internal Medicine in World War II: Infectious Diseases and General Medicine (Vol. III). Edited by Robert S. Anderson, Col. MC, USA; and W. Paul Havens, Jr., M.D., Washington, D. C., 1969, Office of the Surgeon General, Department of the Army. Pp. 768. Illustrated. ($8.25)

This book is the third and last of the clinical series relating to internal medicine and is part of the history of the Medical Department of the U. S. Army in World War II. The individual chapters were written by 24 medical officers and consultants to the Surgeon General and deal with general medicine, infectious diseases, and dermatology.

The volume presents effectively not only the statistics of global military medicine, but also detailed clinical discussions of the variety of diseases covered. It is a good reference source for the clinician, and it has added appeal to the epidemiologist and medical historian. The chapters covering nutritional disorders, viral hepatitis, and environmental diseases are excellent. The tropical disease material is well presented. More than 100 pages are devoted to skin disorders, a frequent cause for removal of soldiers from combat. The book is authoritative and well-written. Illustrations are excellent and the plates depicting the pathology of hepatitis are outstanding. Although they are primarily statistical, the numerous tables are of great clinical interest.

Over-all, the book presents an excellent balance: that is, historical and statistical account of the experiences of internal medicine in World War II plus an impressive discussion of the etiology, clinical picture, control, and management of a wide variety of infectious diseases, some of which were not well-known before the War.

Dominic A. Mauriello, M.D.

Therapeutic Radiology—Third Edition. William T. Moss, M.D. and William N. Brand, M.D., St. Louis, 1969, Mosby. Pp. 564. Illustrated. ($22.50)

The third edition of this well-accepted text is an excellent introduction to the clinical problems of the radiation therapist. The book has been thoroughly revised and each chapter contains a carefully selected bibliography which includes both the classic articles and the recent literature. An illuminating introductory chapter deals with general concepts of radiobiology. Various chapters discuss specific organ systems. Each chapter begins with a consideration of the response of the normal tissues of the organ to radiation and then deals with the clinical considerations guiding therapy, the technics and complications of treatment, and the prognosis. The status of other therapeutic modalities such as surgery and chemotherapy is given proper recognition. Each chapter ends with a concise statement of the authors' own opinion and approach to the problems discussed. Here is a sound, clinically oriented guide which stresses the rationale of radiation therapy.

Leonard S. Ellenbogen, M.D.

Bing's Local Diagnosis in Neurologic Disease. Webb Haymaker, M.D., St. Louis, 1969, Mosby. Ed. 15. Pp. 600 with 395 illustrations. ($32.50)

Back in 1909, Bing's *Kompendium* was offered to the German speaking medical public as a practical volume on neuroanatomy. It won almost instant acceptance, and an English translation was produced right after the end of World War I. This 15th edition comes out under the leadership of Webb Haymaker, M.D., who, now identified as the senior scientist to NASA, has, for decades, been thought of as one of our country's most distinguished neuroanatomists and neuropathologists.

While the price of the book—$32.50—seems a bit high, it must be remembered that there are almost 400 illustrations here, and in anatomy, the pictures and not the text tell the story. The book presents a remarkable marriage of basic anatomy and clinical neurology. Every part of the central and peripheral nervous system is dissected for the reader. This is not the anatomy of the morgue either. Always, structure is correlated with function and the physiology of the neuraxis is delineated as well as its anatomy. This, in turn, is related to presenting clinical symptoms. The tabulations, the line drawings, and the photographs, all combine with the text to produce an understandable explanation. Even such symptoms as disturbances in awareness, memory and behavior, are reviewed in terms of their anatomic and physiologic substrates.

To the neurologist and neurosurgeon this should be a precious book, indeed. And to all doctors fascinated by the interesting, almost geometrical patterns of the operations of our central nervous system, this will be a dependable, and sometimes really exciting volume.

ABRAHAM LEFF, M.D.

Disaster Handbook. Solomon Garb, M.D. and Evelyn Eng, R.N. Ed. 2. New York, 1969. Springer Publishing Company. Pp. 309. (Price not stated—Paperback)

Doctors are expected to play a role in the prevention and treatment of injuries and disabilities resulting from disasters—fires, airplane crashes, highway accidents, ship wrecks, and so on. Yet there is very little in medical school training or private practice to give any doctor (other than a highly special surgeon) any experience in disaster care. The authors here cover major disasters from airplane crashes to volcanic eruptions, from avalanches to tornadoes. For each they review causes, preventive measures, warning signs, and special procedures of rescue and care. Other sections of the text touch on traffic control at accident scenes, the psychology of disaster and panic, first aid and rescue work, triage, shock, resuscitation, and nursing care.

There is nothing quite like this book—a sensible, down-to-earth, practical book which should be a useful companion for the physician or nurse looked to for leadership in a sudden disaster.

VICTOR HUBERMAN, M.D.

Textbook of Pediatrics. (Edition 9). Waldo E. Nelson, M.D., Victor C. Vaughn, III, M.D., R. James McKay, M.D., Philadelphia, 1969, Saunders. Pp. 1590. Illustrations 527. ($21.50)

Here is a virtual encyclopedia of pediatrics, including a table of contents that is a directory of childhood diseases—all for a penny and a half a page! The factual data are well organized and easy to find. This makes the text as valuable to the physician in clinical practice as it is to the student of pediatrics. An impressive group of 81 contributing experts have revised the material in the various sections of this volume. Included is a new section on inborn errors of metabolism which covers the treatment of such recently discovered diseases as methylmalonic acidemia and glycinemia. There is also an interesting appendix entitled "Morphologic Syndromes" which lists these disorders in convenient tabular form for ready reference—and also for games of one-up-manship between physicians (What is Schmid-Fraccaro Syndrome?).

The entire text is set in an easily read style of type, and is well illustrated, including color illustrations for dermatologic diseases. The volume is getting quite bulky, and it would be easier to use if it were bound in two volumes, cost permitting. Everyone in medical practice should have access to this new edition.

SEYMOUR F. KUVIN, M.D.

The Comparative Pathology of Inflammation. Elie Metchnikoff. New York, 1969, Dover Publications. Pp. 224. Illustrations. ($2.75)

This is a collection of the 12 lectures on the comparative pathology of inflammation delivered by Elie Metchnikoff at the Pasteur Institute in 1891. Metchnikoff traces the evolution of inflammation by recording his own observations of the responses of unicellular organisms to injury and to foreign bodies then carrying these observations up the evolutionary scale to the study of vertebrate responses. Metchnikoff, it should be remembered, worked and taught at a time when most pathologists considered the inflammatory reaction to be a morbid process essentially detrimental to the organism. His defense of the hypothesis of a cellular mechanism of *defense* against infection with mobile phagocytes acting in protection of the organism, by the clear exposition of his findings, and by his replies to the criticisms of the biologic theory of inflammation does indeed make refreshing reading.

Research evidence reported clearly and simply in the first person, and comments such as, "Although this conclusion is opposed to the almost unanimous opinion of pathologists, it is nevertheless correct," cannot be boring, even if they are history.

JAMES G. FOLEY, M.D.

Engineering in the Heart and Blood Vessels. George H. Myers, Sc.D. and Victor Parsonnet, M.D., New York, 1969, Wiley. Pp. 198. Illustrated. ($14.95)

Here is a small volume which serves as an excellent introduction (for both the physician and engineer) to the exciting new field of biomedical engineering. It is jointly authored by George H. Myers, an electrical engineer, and Victor Parsonnet, M.D. of Newark Beth Israel Hospital who is well known to physicians in our state, and elsewhere, for his pioneering work in this field. Four forms of artificial internal organs are discussed—pacemakers, the artificial heart, heart valves, and vascular prostheses. Each discussion is preceded by a concise review of pertinent physiology. This is followed by a summary of the basic operating principles of these devices and a description of the materials used in the implanted devices with attention directed to their properties in a biologic environment. Particularly pertinent to current clinical practice is the chapter which deals with the implanted cardiac pacemaker. As a bonus, they include a list of available cardiac pacemakers by various manufacturers. This volume will be valuable and interesting reading for physicians who want to keep abreast of the latest developments in the use of cardiac and vascular devices within the body.

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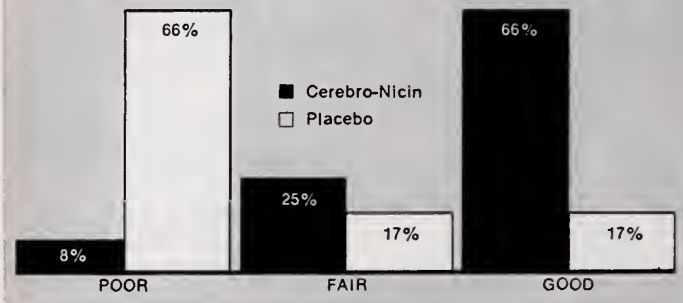
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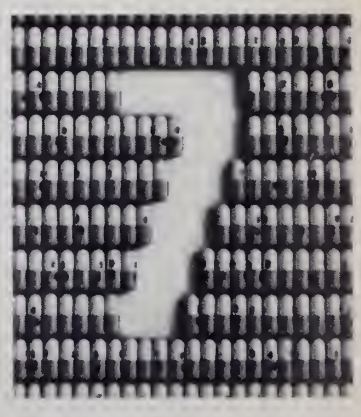
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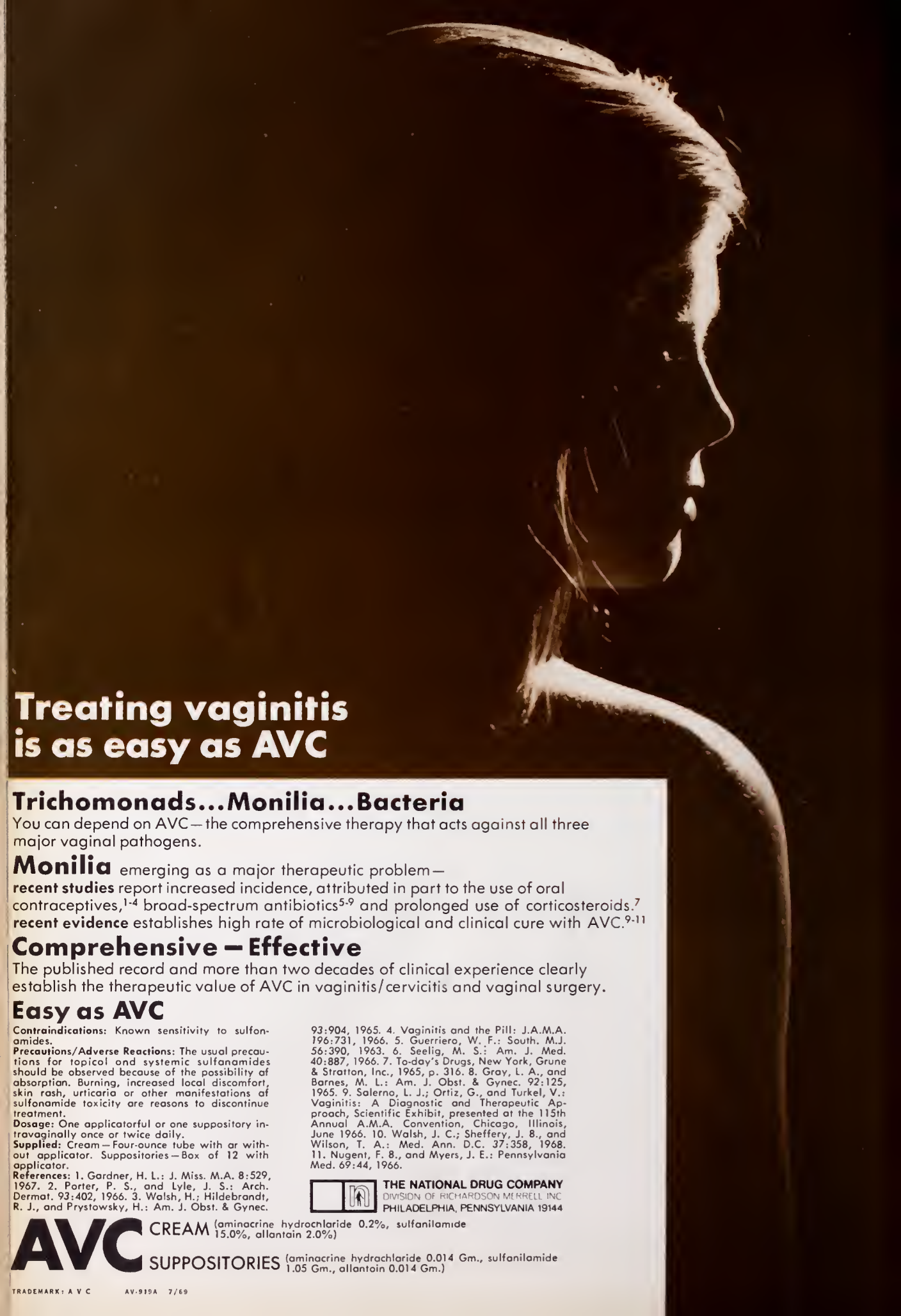
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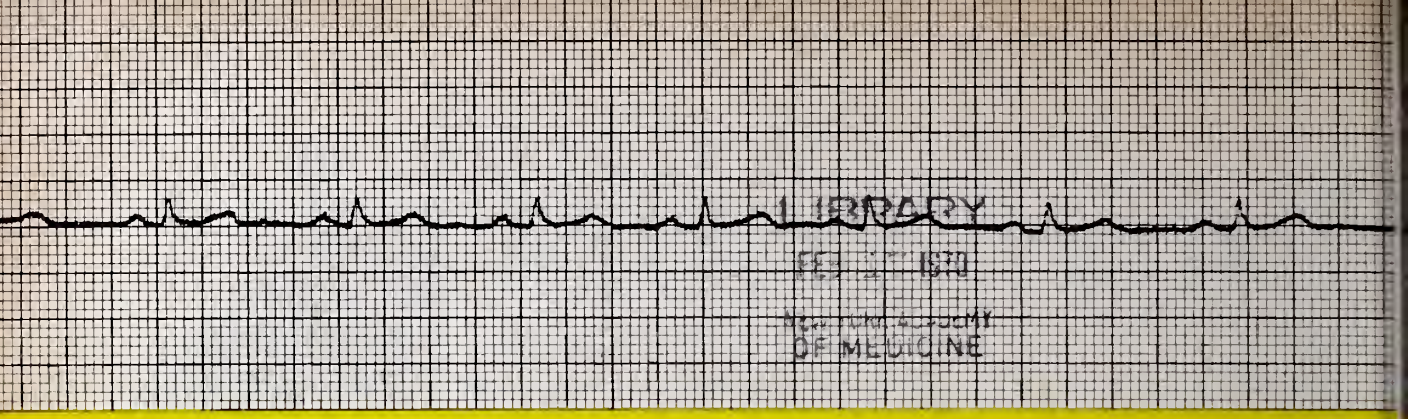
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

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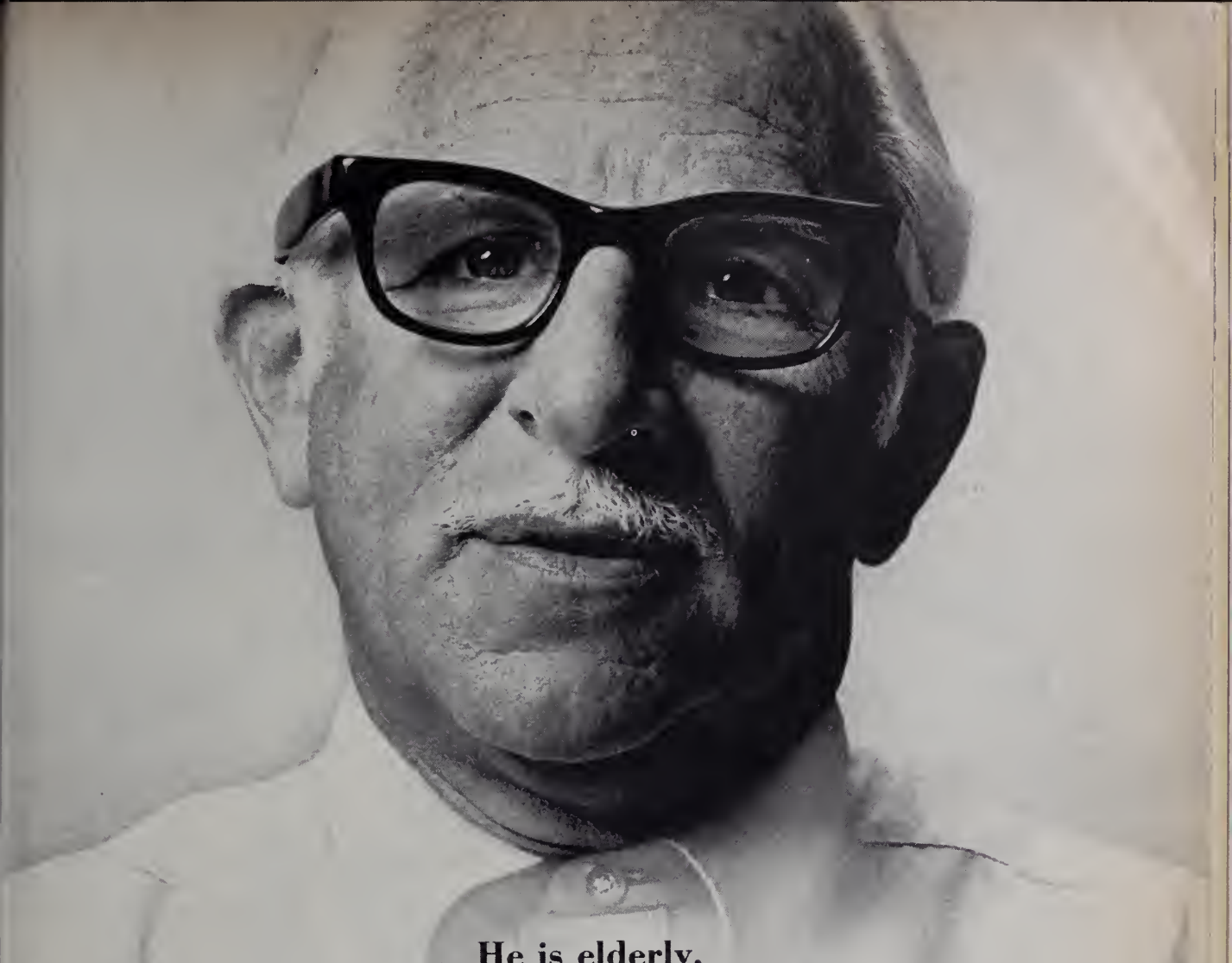
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Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

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A Division of American Cyanamid Company, Pearl River, New York

345-8

during and after infection



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TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

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Fast...long-lasting relief of aches and pains of colds and flu

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Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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MEASURIN®
TIMED-RELEASE ASPIRIN
ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF
Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

Mead Johnson–pharmaceuticals created for your specialized clinical needs

when your patients need continuous potassium supplementation...



they need the proved effectiveness and safety of

K-LYTE®

Each effervescent tablet supplies: 2.5 Gm. potassium bicarbonate (25 mEq. elemental potassium), 2.1 Gm. citric acid, cyclamic acid

Three clinical studies* confirm the effectiveness of good tasting K-Lyte as a source of supplemental potassium to increase low levels of serum potassium and to maintain normal levels. Patients were on continuous diuretic therapy and salt-restricted diets. K-Lyte dosage was one tablet b.i.d.

Serum Potassium Levels (in mEq./L)

Number of patients	Mean initial value	Mean final value
14	3.23	4.83
16	3.50	4.40
25	4.52	4.47

K-Lyte can offer effective potassium supplementation without the gastrointestinal complications sometimes associated with potassium chloride tablets and thiazide-potassium chloride combination therapy. Effervescent K-Lyte is taken in solution, speeding up absorption to avoid these hazards.

Composition: Each tablet contains potassium bicarbonate (2.5 Gm.), citric acid (2.1 Gm.), cyclamic acid, artificial flavor and color.
Contraindications: When renal function is impaired, or if the patient has Addison's disease, potassium supplementation should not ordinarily be instituted.
Precautions: Should not be used in patients with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations.
Side Effects: While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum.
Administration and Dosage: K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement.
How Supplied: Effervescent tablets—boxes of 30 and 250 (orange or lime).

*Reports on file: Medical Research Department, Mead Johnson Laboratories, Evansville, Indiana 47721

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the common denominator in G.U. therapy

In G. U. therapy, the first consideration is control of infection. To your patient, a primary concern is *relief from pain*. URISED provides rapid relief from pain, and relaxation of smooth muscle spasm through parasympatholytic action of atropine and hyoscyamine.

URISED is not a dramatic "wonder drug" but a useful one that has served the medical profession for more than fifty years. You can rely on URISED; it has gained the confidence of physicians who have written more than one million prescriptions for their patients.

URISED is a mild but reliable agent with a low order of toxicity. It can be used alone to treat uncomplicated urinary tract infections where the invading organisms are susceptible to methenamine and methylene blue in an acid medium. URISED can provide "interim therapy" while awaiting complete laboratory diagnosis. It can also be used as an adjunct (to relieve pain and spasm) with almost any other form of antibacterial therapy).

For prompt relief of the distressing symptoms of pain, burning, frequency, dysuria, and spasm, consider URISED. Your patient will recognize its presence by the characteristic blue-green urine.



keeping your patient comfortable

PRECAUTIONS: Administer with caution to persons with known idiosyncrasy to atropine or cardiac disease.

SIDE EFFECTS: Neither irritation nor other untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—Initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

Stocked Nationally Through All Service Wholesale Druggists

URISED®

Each blue-coated tablet contains active:

Atropine Sulfate	0.03 mg.	Methylene Blue	5.4 mg.
Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

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typhus fever
urethritis

...don't you think it's time we were on a first-name basis?

call me "Achro® V"



Every pharmacist knows ACHRO® V stands for ACHROMYCIN® V

Contraindications: Hypersensitivity to tetracycline.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, throi bocytopenic purpura, neutropenia, eosin philia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

Achromycin® V
Tetracycline

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A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

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Every doctor's worst patient.

It's probably himself.

Statistics show physicians suffer more than their share of ulcers, high blood pressure, heart disease, and other ailments.

What's to blame? Maybe good intentions. No doubt many medical men neglect their own health to look after their patients.

Still it's a waste. And we'd like to remind New Jersey physicians that a healthy doctor can be of better service to his patients and private medicine.

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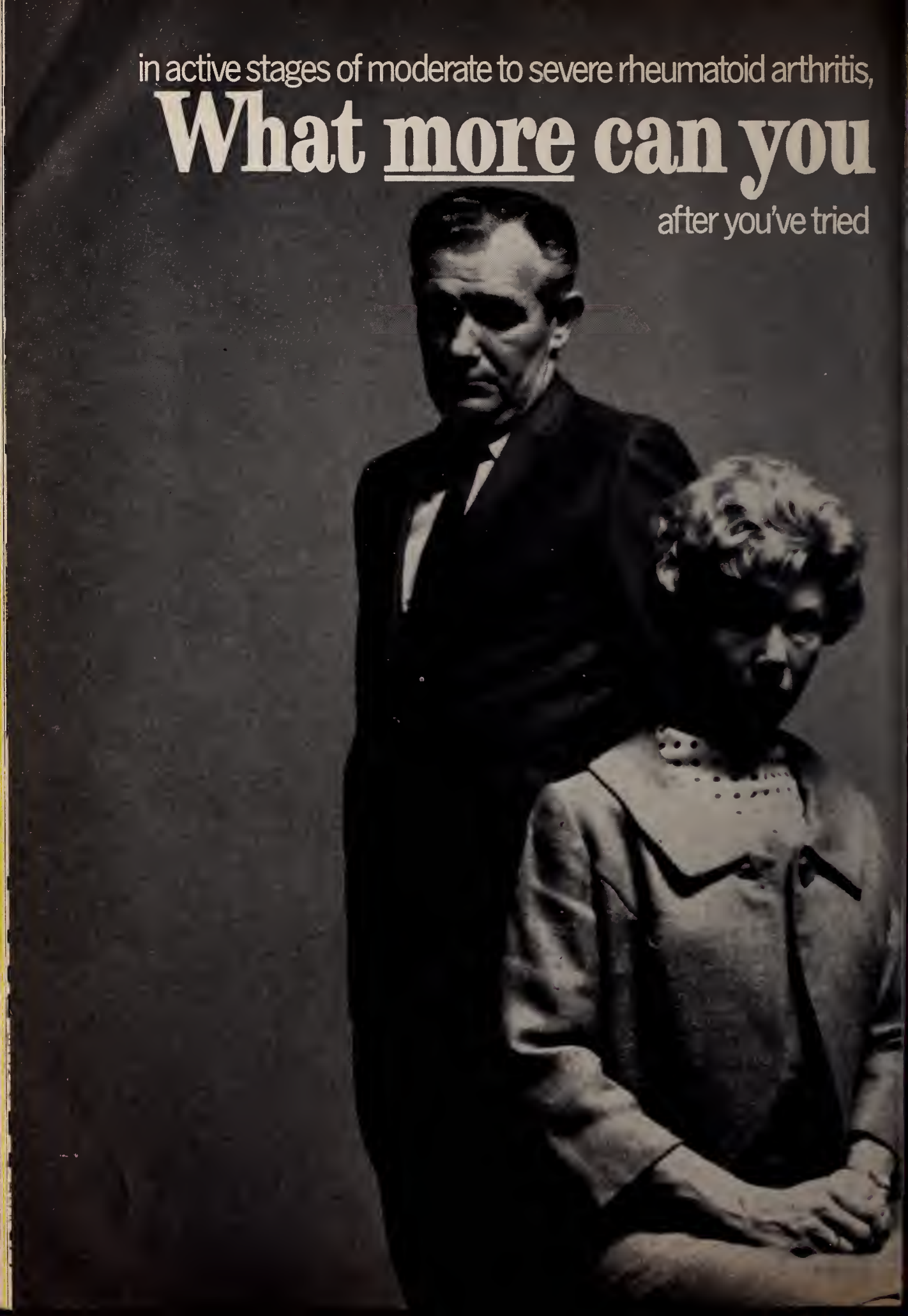
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Fight waste.
Help keep private medicine private.

in active stages of moderate to severe rheumatoid arthritis,

What more can you

after you've tried



rheumatoid spondylitis, and osteoarthritis of the hip

do for these patients?

salicylates and rest



INDOCIN®

(INDOMETHACIN | MSD)

helps relieve pain, fever,
swelling, and tenderness

Please see new prescribing information on following page.



REVISED PRESCRIBING INFORMATION

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Indications: Symptomatic relief of adult rheumatoid and degenerative joint disease unresponsive to adequate trial of salicylates and other measures of established value, such as appropriate rest. Has been found effective in active stages of: 1) moderate to severe rheumatoid arthritis including acute flares of chronic disease, 2) moderate to severe rheumatoid (ankylosing) spondylitis, and 3) moderate to severe degenerative joint disease of the hip (osteoarthritis of the hip). Has been found effective in relieving pain and reducing fever, swelling, and tenderness in acute gouty arthritis in selected patients. May enable reduction of steroid dosage in patients receiving steroids for the more severe forms of rheumatoid arthritis; in such instances the steroid dosage should be reduced slowly and the patients followed very closely for any possible adverse effects.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

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SUSTAINED-RELEASE VITAMIN C



CEVI-BID

500 mg. capsules maintain optimal levels around-the-clock on b.i.d. dosage

When Vitamin C is taken in ordinary tablet form, the rise in blood levels is rapid, but Vitamin C is as rapidly excreted and blood levels drop accordingly.

In CEVI-BID, medication is released at a smooth, continuous, predictable rate dependent only upon the presence of fluid in the G.I. tract and independent of pH or other variables.

CEVI-BID maintains optimal blood levels of Vitamin C, and avoids "peak and valley" effects of ordinary Vitamin C tablets.

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new 10% solution...
particularly convenient for home use

MUCOMYST®-10
(ACETYLCYSTEINE)

liquefies thick, viscid mucus in chronic bronchitis and emphysema

Mucomyst, as 20% acetylcysteine, has been used with safety and effectiveness in hospitals for over five years.

Now a new 10% solution, Mucomyst-10, offers you the choice of prescribing a lesser concentration whenever you feel this is desirable. It provides added convenience and simplicity, particularly for your patients using nebulizing units at home.

By including Mucomyst-10 in the home management regimen, you can provide full mucolytic benefits for many of your patients with chronic bronchitis and emphysema complicated by tenacious secretions.

Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings: After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched carefully. If bronchospasm progresses, this medication should be immediately discontinued. Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied: Mucomyst-10 (acetylcysteine)**, a sterile 10% solution, in vials of 10 ml. and 30 ml.; **Mucomyst (acetylcysteine)**, a sterile 20% solution, in vials of 10 ml. and 30 ml.

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The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—

Recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]

Recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.

Precautians/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, J. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.014 Gm.)

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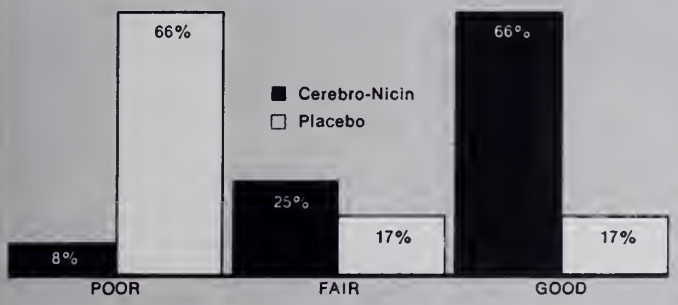
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For the treatment of the aging patient

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir 8 oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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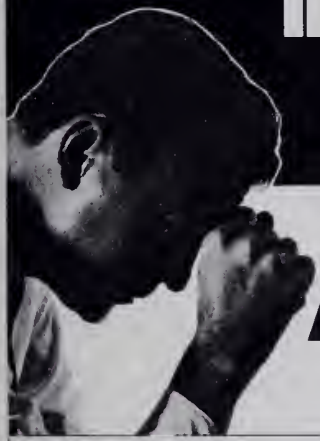
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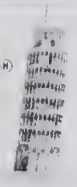
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EDITORIALS

The Drug Epidemic

Drug abuse has become an epidemic—there seems to be no better word for it. In this issue, we publish an article by Dr. Hans Freymuth (page 128) on the possibility of using methadone, and a column from the New Jersey College of Medicine and Dentistry on their innovative and vigorous attack on the problem. They are concerned not only with direct treatment but also in training professionals in the field.

Like all epidemics it seems to be contagious, though in this case the contagion is emotional rather than by bacteria or viruses. Like most epidemics, it has areas of prevalence and areas of light incidence.

The medical profession has not played a dynamic role in assaying the cause and blueprinting the control of this epidemic. It seems fair to say that the person who abuses a drug is trying, thereby, to say something. It seems fair to say that the roots of the addiction lie somewhere in the ecologic-social-cultural-economic-interpersonal matrix of conditions in which our young people grow. It would appear, at least superficially, that there are two different kinds of drug abuse: the addiction to heroin found chiefly in the slum areas of big cities and an enchantment with other drugs—barbiturates, mescaline, amphetamine, L.S.D., marijuana, and even glue sniffing, which seems to involve middle class (though frequently rejecting the middle class label) young people, often from comfortable suburban homes. The conventional opinion is that these represent two different epidemics—different psychologically, culturally and medically. At least that is the usual opinion. But this may be only our middle class snobbery. Perhaps there is no difference psychologically.

One wonders if this drug epidemic is not actually another face of middle class America's passion for alcohol and other medication anyway. So many of us drink on almost every social occasion and it is hard to persuade the son or daughter that the use of ethyl alcohol for relaxation or flight from reality is commendable while resort to pot for the same purposes is evil. Almost every middle class home in our state has, stocked in its bathroom cabinets, a supply of barbiturates, tranquilizers, mood elevators and/or pain-killers. It is not beyond the realm of possibility that we of the older generation have set this tune. Man is probably the only animal who chooses to take pills.

There is a bewildering array of well-meaning, but often amateurish, organizations devoted to handling the addict. The medical profession has provided little leadership here. One of the heartening things about the College of Medicine's, durg abuse program is that here, at least, is a project that has medical leadership and that tries to integrate these scattered efforts.

Most epidemics burn themselves out in time. Shall we sit by and wait for that to happen?

Peer Review

Some physicians object to the time needed to review the quality and quantity of work done by other doctors. Some resent the implication that their confreres need policing. Elsewhere in this issue (page 137) we abstract an interesting paper on the subject by Richard Wilbur, M.D., the AMA's Assistant Executive Vice President. It is worth considering what Dr. Wilbur is saying. And there is an added factor here. Medicine is one of the few professions (law is another) where the brotherhood itself reviews the work of its colleagues, instead of having the review accomplished by someone outside the fold. This is a precious privilege, and one way to preserve it is cheerfully to cooperate in the labors of peer review, and to do it fearlessly. One thing is sure. If we don't accomplish it, some other group will.

The Fading Imagery Of Medical Words

Miliary tuberculosis, the professor told us back in 1925, is so called because the tubercles were the size of millet seeds. This was supposed to give us the picture. Half of us were country boys who knew that millet was a grass called *Panicum milleaceum*. But the city lads had never handled millet seeds. So our picture of millet seeds came from inspection of the tubercles, not *vice versa*. Then there was water-hammer pulse. This was intended to be a very vivid description of Corrigan's pluse—but most of us had never seen, felt, or heard a water-hammer in operation. And the wine press of Herophilus! Wonderful anatomic imagery here, provided you had seen a wine-press yourself. In those days we did know what horse shoes looked like so we could picture a horseshoe kidney. But today's medical student (homo urbaniensis) has never actually seen a real functioning horseshoe; so he has to get the picture from good luck floral wreaths. Then there is that folded fundus gall bladder still called a "Phrygian cap." Know where Phrygia is and what kind of caps the natives wore?

Our pathologist didn't like to refer to amyloid degeneration. He preferred to call it "sago spleen" because, he said, it was such an accurate pictorial image of what the spleen looked like.

But how did we city slickers and suburban residents know what sago looked like? The dictionary says it's the pith of the *Metroxylon rumphii,* but what's that? The kind of vocal resonance known as egophony is not, as you might suspect, the sound (phoney) of an egoist (ego), but rather is the bleating of a goat (Greek *Aigos,* goat). Fine, but today's medical students never hear goats bleating. The duckbill speculum is named for a small aquatic mammal (*Ornithorhynchus Anatinus, as* everybody knows) but where is the model from which to get the picture? The little stapes, you know perfectly well, is so-called because it is shaped like a stirrup. But most of us suburbanites can visualize a stirrup only by first recalling what the stapes looks like. To the 18th century gentleman, saber shin was a wonderful description of the luetic tibia—but what doctor in the mid 20th century can tell a saber from a scimitar?

Cracked pot resonance is a beautiful phrase, but where in the modern household can one find a cracked pot on which to get the original sound? Who remembers now what the railroads have to do with railroad spine? A relic, too, of a simple age is housemaid's knee, a type of bursitis now more common among the chatelaines themselves than among their scarce domestic assistants. And chimney-sweeps' disease: are there any more chimney-sweeps in business? Who knows enough about saddles to recognize a saddle joint? Would our youngest ophthalmologists today know what is meant by "trolley-eye?"*

Naming diseases for occupation may not be scientific, but it makes for a colorful terminology. And how about such image-provoking labels as coffin joint, cobblestone tongue (what does the development-dweller know of cobblestones today?), black-water fever, mossy foot, and rake teeth.

Two centuries ago an imaginative anatomist found a name for that hollow on the radial side of the wrist produced when you abducted the thumb. It was the *anatomical snuff box,* for in those days every educated man knew what a snuff box looked like. But you—when have you last seen a snuff box?

Medical knowledge now is tough to come by. Our field of vision probes deeper so it must get narrower. No longer can we roam all over the periphery of life, calling ourselves "natural philosophers" and taking our terminology from all the nooks and crannies of the world of scholarship. Our vocabulary, like the operating room, is becoming a model of sterility.

* It's like this. Once when your father was a little boy there was a vehicle called "trolley-car." The operator wielded a brass handle. Bits of brass dust would get on his moist finger-tips. When he rubbed his eyes, he might get a conjunctivitis. But doesn't trolley-eye sound much more interesting than conjunctivitis?

ORIGINAL ARTICLES

Injuries to attendants were noticeably reduced, with no serious effects to patients, when a tear gas preparation was used as a last resort.

The Clinical Use Of Chemical Mace®*

Martin H. Weinberg, M.D.; Charles C. Buford, M.D.; Ivan F. Bird, M.D.; and Michail Rotov, M.D./Trenton

Chemical Mace® was developed in 1965 by the General Ordnance Equipment Company of Pittsburgh, Pennsylvania. Its active ingredient is alpha-chloroacetophenone (tear gas), dissolved in an organic, carrier-solvent compound at a concentration of about 0.9 per cent. This is compressed in a canister along with a freon gas-type propellant. Chemical Mace® is delivered in droplets, in a process similar to the operation of commercial aerosol-type sprays. The exact proportions of this formula have not yet been made public by the manufacturer. It is said to contain no skin-penetrating chemicals and "within the parameters of the Federal Hazardous Substances Labeling Act, Mace® formulation is not even classified as an eye irritant."[1]

However, experimental and clinical studies have reported irritant effects by chemical Mace® on the eye, skin, and respiratory tract mucosa.[2] These untoward effects were found to bear a direct relation to such variables as distance, direction, duration, and area concentration. When Mace® is properly used, the incidence of side effects lessens and may be negligible. Washing exposed areas with water soon after Mace® had been sprayed has also served to limit local area irritation.[3] With limited exposure, significant tissue injury is not apparent and within a few hours total effects are minimal or absent. The manufacturer states that competitive devices on the market of different formulations have caused some injuries "attributable to excessive chloroacetophenone content and/or an inept choice of carrier-solvents."[1] Delivered as a spray, it spreads chloroacetophenone carried by solvents which prolong exposure until the solvent evaporizes. Incapacitation results from reflex closure of the eyelids and holding of the breath to prevent inhalation. Exposure to tear gas by other means such as tear gas pistol or tear gas pen has resulted in physical injuries attributable to the explosive charge, effect of, or damage from particulate matter.[4,5]

Newspaper accounts describe numerous instances of the use of chemical Mace® as a non-lethal means of behavior control. Alcoholics, drug addicts, and mentally disturbed patients have been reported to show little or no calming effect after exposure. Extremely violent or enraged persons have been described as being able to "override" the effects of Mace®.[6] In such cases, function remained operative but at a reduced, less efficient level.

In a report summarizing their findings, the Department of Pharmacology of the University of Michigan Medical School stated: "There is neither evidence nor scientific rationale to support the view that significant systemic effects on the nervous system or other organ systems, other than the psychological responses to being incapacitated, are induced by chemical Mace®, even by exposures which could produce significant injury to the eye, skin, or mucous membranes."[4]

Although the availability of tranquilizers has considerably reduced instances of combative

* This work comes from the New Jersey State Hospital at Trenton, where the four authors are on the staff. Dr. Weinberg is Chief Executive Officer and Dr. Rotov is Deputy Medical Director.

behavior on the wards of public mental hospitals, the Trenton State Hospital still faces this problem in its Forensic Psychiatry Section. This is a maximum security section, which houses mentally ill offenders in their pre-trial and post-trial period. A number of uncontrollable patients are sent here from other State institutions for temporary management.

The administration of sedation to a violent patient continues to present a problem even in a specialized hospital such as our Forensic Section. The potential for injury to the patients and the personnel remains high. Mindful of this, the Medical Director approved the use of chemical Mace®, when indicated, under proper supervision. Mace® was made available for use in the Forensic Psychiatry Section in August 1967. This unit includes sections for male and female patients and is maintained and staffed by specially trained personnel. Assigned physicians make the decision regarding the use of Mace® in given situations. It is administered by supervisory personnel *after all other efforts to placate the patient without the use of force* has failed. In such instances when the use of Mace® appears indicated, it is sprayed at the patient from a distance of not closer than five feet. Following exposure, cold water flushing of the eyes and skin is performed. The patient is then seen by a physician for examination and evaluation.

This report represents a survey of material obtained from the following sources within the Forensic Psychiatry Section: (1) A recorded data sheet for each patient exposed. This includes indications for use, effectiveness, condition of patient as observed following exposure, effect on personnel in the immediate area, patient comment, and remarks of the examining physician. (2) Observations and opinions expressed by ward personnel and the administrative and medical staffs. The period covered is from August 1967 to August 1969. In these two years, 44 patients required control with the aid of Mace®. Of these, only seven were females. In a few patients, Mace® was used more than once; however, no one was exposed more than once in any day. Indications for administration were grossly disturbed behavior with the immediate probability of the patient harming himself or others.

The dimensions of the destructive behavior in our Forensic Section's patient population are significantly influenced by the patient's legal status and peculiar environment. Depending on whether he has been sentenced, whether he is expecting parole, or whether hopes for it have been crushed—the patient may, consciously or unconsciously, over-play or under-play his psychosis. The feeling of hopelessness and desperation about a long term sentence adds a realistic load to his psychopathology and leads to a sometimes delayed explosion. Many patients, especially those with low intelligence, exhibit almost phobic inability to accept spatial restraints and their outbursts assume hysterical overtones. Destructive tendencies are much more frequent than among the general hospital population and this makes control more difficult. This destructiveness is not due to inherent "criminal insanity" of the patient, but more often than not is the result of the legal and environmental circumstances that rob the patient of hope or make his future seem bleak.

Most patients were easily handled following exposure to Mace®. Burning of the exposed skin and tearing of the eyes with lid closure appear to cause sufficient disability to result in the loss of will to maintain the aggressive drive. Breath holding, apparently reflex as lid closing, serves to limit the burning sensation of the throat, tongue and mouth. As a rule, where Mace® was effective, the patient would cease his aggressive activity instantaneously, withdraw, and in many instances sag to the floor. Of those who did not respond favorably, there was no distinctive diagnostic group correlation.

Two male patients who were able to withstand the effects of Mace® exposure belonged in the category of personality disorders. Seven male patients comprised this group of addicts, sex offenders, or patients with other antisocial tendencies. The other diagnostic group

included 30 males and 7 females. They were considered psychotic and were either schizophrenics, mentally retarded with psychotic reaction, or organic brain syndromes with psychosis. Four males and one female patient did not show the desirable responses to Mace® in this group.

Some attendants in close proximity to the patients when the spray was released (or those whose assignment included first contact with the patient after spraying) reported tearing of the eyes and burning sensation of some areas of the exposed skin. However, unlike tear gas of other formulae, the area on which Mace® was used did not long remain contaminated.

A comparison of attendant injury records for the period Mace® was used, with an equal time period prior to its use, indicates a considerable reduction in employees' injuries. Undoubtedly this contributes to the staff morale and job satisfaction. During the period of two years following introduction of Mace® (August 1967 to August 1969) there was only one recorded instance of attendant injury with subsequent loss of work days when the Mace® was applied. In four other instances, the attendants were jumped unexpectedly, without an opportunity to use the spray. On the other hand, during an earlier two year period there were nine incidents of attendants' injuries under the circumstances where Mace® could have been applied if it had been available. The reduction of attendants' injuries was accompanied by a comparable reduction in patients' injuries, although this is difficult to document.[7]

Since the main purpose of introducing chemical Mace® was to reduce patient injuries and shorten their state of destructive delirium, it is significant that only one patient verbalized his objections to the use of spray. In this instance the spray was not effective and the patient had to be physically restrained. Patients' relatives also have not protested the use of Mace®, although in the Forensic Psychiatry Section they tend to be somewhat more demanding and more protective of their kin.

In three instances another brand of spray deterrent was used, but this was discontinued after unsatisfactory response. This particular formula was observed to cause lacrimation, but the patients became more agitated following its use.

Summary

This paper sums up a two years' experience in the use of chemical Mace® at the Trenton State Hospital's Forensic Psychiatry Section. The available literature with respect to the composition, action, use and effects of chemical Mace® have been reviewed. It was found that in 44 patients (male and female) exposed to Mace® at the peak of their destructive activity, all but seven responded satisfactorily. Following the introduction of Mace®, we noticed a substantial reduction in injuries to attendants handling disturbed patients. It is concluded that Mace® in such crises situations has been of benefit to both patients and personnel, without any harmful after-effects to the patients.

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Station A

The "harmless" pessary can be a death-dealing device, and here is a case to prove it. All pessaries, says this author, should be removed.

A Pessary Can Be Dangerous

Eberhard Mueller-Heubach, M.D.
New Brunswick*

At the close of the last century and the beginning of this century the use of pessaries was widespread. They have become less popular in the last few decades and upon review of the literature since 1950, I found only a small number of papers on pessaries. Novak[1] in the 1965 edition of his textbook quotes the words of Bantock[2] in 1905, "I am not aware that there is on record a single case in which a woman lost her life through the use, or even the abuse, of a vaginal pessary."

Prolapse of the uterus, uterine retrodisplacement and contraception have been the prime indications for the use of pessaries in the past. Due to progress in anesthesia and surgery very few patients with prolapse represent a poor risk for surgical intervention nowadays. Contraception is achieved mainly by oral contraceptives or by intrauterine devices. In spite of all this, we should keep in mind that there *are* still women wearing neglected pessaries which may cause complications a long time after insertion. A dramatic illustration of this fact is the following in which a woman lost her life because of a stem pessary.

A 60-year old woman was seen in 1961 in the Outpatient Department because of pruritus vulvae. No pelvic examination was done and she failed to appear for laboratory tests. On April 15, 1962 the patient was admitted *via* the Emergency Room with abdominal distention and pain over the entire abdomen, more marked in the epigastrium. This had begun two days prior as a vague abdominal pain accompanied by vomiting. She had no bowel movements since the onset of these complaints. There was a grade III systolic murmur over the mitral and pulmonic areas. The abdomen was distended and tympanitic without rebound tenderness. Slight muscle guarding was present. Bowel sounds were absent, no mass was palpable. Rectal examination was negative. No pelvic examination was done. A diagnosis of intestinal obstruction was made although flat plate of the abdomen on April 16 did not reveal anything indicative of intestinal obstruction.

On April 16 at 9:00 a.m. the patient was seen by a surgeon who found her acutely ill, sweaty with labored respirations, and a Levine tube draining coffee ground fluid. Barium enema revealed a normal colon. An elongated rectangular density measuring approximately one and a half inches in length was seen in the pelvis outside the bowel and was thought to be a foreign body on the abdominal wall At 4 p.m. the blood sugar was 452 mg. per cent, BUN 24.4 mg. per cent, urine showed 4+ sugar and 3 plus acetone. Electrocardiogram showed sinus tachycardia and anoxic effect. At 6 p.m. she went into shock and became comatose. Blood pressure was not obtainable but through administration of Levophed® and Wyamine® could be brought up to the level of 70, systolic. Pupils were dilated and nonreactive.

Urinary output at 11 p.m. was only a few drops which contained a trace of acetone and 4 plus sugar. At this time she was cold and sweaty. Respirations were jerky and labored and a macular erythema was present over the abdomen. The impression was that the patient was in toxic shock probably secondary to intestinal perforation. On April 17 at 5 a.m. she died.

At autopsy, Dr. Moolten reported that the *situs viscerum* was altered by widespread acute inflammation of the serous membranes together with an effusion of about 300 cubic centimeters of turbid and greenish-yellow slightly odorous fluid. The coils of bowel were agglutinated together throughout and to the parietalis and were considerably distended with gas and showed much discoloration. A smear of the material revealed gram-negative bacilli and gram-positive cocci. The uterus was somewhat enlarged and discolored on its anterior upper surface near the right border where there was an area of greyish-black discoloration which was extremely soft and friable. Gentle pressure at this point disclosed an opening through which turbid greenish-grey purulent exudate exuded in abundance into the free peritoneum. When the uterus was dissected a large cavity replaced the normal cavity, resulting from secondary suppuration of most of its inner wall and necrosis of the lining tissue. The cervix throughout its extent was occluded by a large metal stemmed pessary fitting tightly into the cervical canal.

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Figure 1—Stem pessary *in situ*

Some surface ulceration was present about the external os of the cervix and surrounding vaginal wall (see the figure).

On microscopic examination of the uterus, a large area of diffuse inflammation extending from endometrium into the muscle layer was found. Sections through the cervix showed marked inflammation and fibrous thickening of the muscosa extending into the deeper layers. A large area of necrosis with a line of demarcation formed by fibrinopurulent exudate was present in the outer layer. The adrenals showed marked stress breakdown. In the kidneys occasional lumpy glomeruli characteristic of Kimmelstiel-Wilson lesions were seen. The remaining autopsy findings were non-contributory.

This case confirms once more the absolute necessity of a pelvic examination in each female patient. Regular examinations are particularly important for women with pessaries because of the complications arising from neglected pessaries. Some patients even forget that a pessary has been inserted until complications occur.[3] Review of the literature since 1950 for complications of pessary treatment, turns up five cases in which the cervix prolapsed through a ring-shaped pessary causing strangulation.[4,5,6,7,8] Removal of these pessaries from the edematous cervix was usually very difficult. Severe ulcerations of the vaginal wall have been seen in many cases.[3,9,10] Another hazard of neglected pessaries is carcinoma at the site of chronic irritation caused by the pessary. Russell[10] reported six such cases of primary cancer of the vagina. Other cases were described by Pommerenke[3] and by McElin and Paalman.[4] All these complications occurred in patients with prolapse of the uterus treated with a pessary. The "dangerous vaginal pessary"[10] should therefore be avoided in the treatment of prolapsus uteri and the patient who refuses surgery should be made aware of these possible complications. With the modern concepts of anesthesia, even in the elderly "poor-risk," surgery can be performed. Most surgeons prefer the Le Fort's colpocleisis in these patients.

In our case the pessary had been inserted for the purpose of contraception. Complications of this method have been pyometra[11] due to salpingitis in a case with tightly fitting pessary in the cervix and cases of perforation of intrauterine ring pessaries[12,13] through the uterine wall. Contrary to the asymptomatic perforation seen with modern intrauterine devices,[14] these patients presented with acute abdominal symptoms. Pommerenke[3] reported the perforation of a wire-like contraceptive pessary into the rectum eight years after insertion.

Today, there is no place for the old intrauterine pessaries. They have been replaced by the intrauterine devices (preferably the Lippe's loop) and oral contraceptives. Nevertheless there are still women who have intrauterine pessaries inserted. These devices may cause complications a long time after insertion, as seen in this fatal case. And, of course, there *have been* cases of neglected intrauterine pessaries in which serious complications never developed. Such a case was described by Brubakk.[15] He observed a 78 year old woman with discharge who had worn an intrauterine pessary for 41 years continuously without any complaints. In spite of this exceptional case, we believe that *all* pessaries used for contraception should be removed and replaced by intrauterine devices or by prescribing oral contraceptives even in patients in which the pessary is only an incidental finding on routine pelvic examination. The fatal outcome in our patient justifies this thinking.

Summary

A 60 year old woman died within three days from peritonitis caused by a stem pessary. Complications of pessary treatment in the

literature since 1950 are reviewed. Surgery for prolapsus uteri is advocated instead of pessary treatment and removal of all pessaries for contraception is recommended. Intrauterine devices or oral contraceptives are favored for contraception.

I am grateful to Dr. Sylvan E. Moolten for advice and assistance in the preparation of this paper.

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180 Somerset Street

School Integration Being Accepted

School desegregation generally improves the feelings of students, teachers, and parents toward desegregation, according to an attitude survey made by the Department of Health, Education, and Welfare. The survey, conducted in the spring of 1969, involved interviews of some 1230 students, parents, teachers, and school administrators in 13 school districts that had experienced some desegregation for two years. The districts were located in Florida, Georgia, Mississippi, South Carolina, and Tennessee.

Roughly nine out of ten of those interviewed felt that the whole school desegregation process worked much better than had been generally anticipated. Only a minority of white parents felt that academic standards were dropping and that unfortunate social results would follow, but white students and teachers only rarely expressed such fears.

Seven out of ten Negro students in desegregated schools felt they were getting a better education than had been available to them in segregated schools. The progress of the white students was not affected. Faculty desegregation was viewed as successful by almost all white teachers and students.

Desegregation operated better at the elementary grade level. High school teachers and students perceived varying degrees of tension and hostility in their schools. Such feelings were stronger in the first year of desegregation and at the start of the school year than later.

The primary factors in determining what happens within a desegregated school are the roles of administrators, principals, and teachers, according to the report. These roles were seen by those interviewed as more important than the attitudes of the community.

In this unusual case, rapid desensitization to procainamide was accomplished, only to be followed by agranulocytosis.

Desensitization To Procainamide

Charles R. Ream, M.D. and Robustiano Barrera, M.D./Elizabeth*

Quinidine and procainamide hydrochloride are two of the most effective drugs in the treatment of ventricular arrhythmias. When their use is essential and the patient manifests sensitivity to both, the physician is presented with a serious problem.

We encountered such a case and rapidly desensitized the patient to procainamide with methylprednisolone. To our knowledge *this is the first time this rapid method of desensitization has been reported with procainamide.* Two and one half months after desensitization, the patient developed agranulocytosis. But he recovered completely from this.

The patient was a fifty-two-year-old male who sought medical advice after noticing "skipped heart beats." These were accompanied by an uncomfortable feeling in the head, neck, and chest, and he manifested severe anxiety. These skipped beats occurred more toward evening but he thought there might be a tendency for them to increase with activity. There was no other history to suggest heart disease. He did not smoke or drink tea or colas. He drank four cups of coffee a day, and one cocktail each evening. He had been seen yearly for health evaluation over the past four years, and there was nothing to suggest heart disease by history, electrocardiograms, physical examination, chest x-rays, or laboratory tests. He was a tense, "nervous" patient. Blood pressure was 120/80. Auscultation confirmed the presence of premature ventricular contractions. Aside from these auscultatory findings, hemorrhoids, and the obvious anxiety state, the physical examination was non-contributory. Blood counts, urine analyses, and blood chemistries were normal; so were chest x-rays. Electrocardiography confirmed the presence of uniform premature ventricular contractions at a rate of 20 per minute. Otherwise the EKG was normal and (except for the PVC's) showed no change over cardiograms taken over the past four years.

The premature beats were explained to the patient, and he was advised to rest a few days and to stop coffee and alcohol. He was placed on phenobarbital because of the extreme anxiety. The patient was seen two days later because he experienced an episode the night before of "extremely frequent skipped beats" which caused him to feel faint and nauseated. He broke out into a cold clammy sweat. At the time of examination, he had 10 PVC's in one minute's time, but three occurred in a row. This was confirmed by EKG. The patient was admitted to the hospital on March 6.

Quinidine sulfate was given, 0.2 Grams every four hours after a test dose had no adverse effects. Phenobarbital 64 milligrams was continued and given every six hours. (The patient had had phenobarbital on frequent occasions in the past with no adverse effects). All laboratory work was normal. Electrocardiograms showed no PVC's over the next few days although an occasional PVC was heard on daily routine auscultation. The patient was ready for discharge on the morning of March 11, when he developed a chill and spiked a fever to 102. He felt perfectly well except for sweats, chills, and fever. The white count remained at 9300. The transaminase rose from 10 to 46. No infection could be documented. The cardiac status was good. It was considered that the patient had a drug reaction to quinidine and this was stopped. Blood, urine, and throat cultures were negative. The fever subsided, and the temperature returned to normal after three days, as did the blood count and transaminase.

Because PVC's returned, the patient was started on procainamide hydrochloride 0.5 Grams every six hours. This controlled the PVC's well. Before discharge he was challenged with phenobarbital with no adverse effects. He was discharged on March 20.

Ten days after starting the procainamide, the patient developed marked urticaria and itching. This was most severe within 20 minutes after taking the drug. Procainamide was discontinued. Weekly blood counts and lupus preparations had been normal and were normal on the day the drug was stopped. The PVC's returned and the patient's anxiety became more severe. Phenobarbital, meprobamate, and chlordiazepoxide hydrochloride (used separately) failed to allay the patient's anxiety caused by the PVC's. He was started on diphenylhydantoin. This was helpful, but the dose needed to control the PVC's was large and it affected his work as he became drowsy and dull. The drug was given with folic acid, but there was no improvement. These drugs were given over a period of three months time, but he could not tolerate the diphenylhydantoin because it dulled his perception so much. Blood counts were taken weekly during this time, and

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were all within normal limits. Diphenylhydantoin had to be stopped.

Anxiety over the premature ventricular contractions had, by now, become a major problem and seriously affected his work. Because of this, it was decided to try to desensitize the patient rapidly to procainamide hydrochloride using steroid in the form of methylprednisolone. The patient was fully informed that this was the first time to our knowledge this had been done. He was fully briefed on the potential adverse reactions that could take place. He consented to go ahead with the desensitization procedure on an outpatient basis. He was seen daily. The dosage schedule used is that shown in the table.

Desensitization was successful and uneventful and no further urticaria or any other toxic manifestations were noticed. The PVC's were well controlled and his anxiety state disappeared. Blood counts and lupus preparations were done weekly and all were normal. Two and a half months after desensitization, the patient developed a sore throat without fever. The rest of his family also had sore throats. Physical examination was then normal except for a markedly inflamed throat and gums. At this point, his temperature was normal. Blood count showed 2,000 leukocytes with 98 per cent lymphocytes and 2 per cent monocytes. Hemoglobin was 11.7 Grams. Hematocrit was 37 per cent. Platelets numbered 220,000. Reticulocyte count was 2.2 per cent. ESR was 74 mm/hr. All other laboratory work was normal.

He was re-admitted to the hospital on August 14. Throat culture revealed normal flora. Blood cultures were negative. The patient was placed in isolation. Oral hygiene was strict, and no tooth brushing was permitted. A soft diet was ordered. On August 16, his temperature was 103. At this same time, his hemorrhoids began to give him great trouble and there was some bleeding. Blood cultures were negative. On that day we started him on aqueous penicillin 1,200,000 units at first and then 600,000 units intramuscularly every six hours. Meticulous sterility precautions were taken before each injection. Streptomycin, 500 milligrams, were given intramuscularly every twelve hours. He did not take adequate fluids by mouth so infusions were started. When this was done, aqueous penicillin was incorporated into the infusions in the amount of 20,000,000 units a day, and the intramuscular penicillin was discontinued.

On August 20, the hemorrhoid condition became alarming and streptomycin was stopped and kanamycin 0.5 Grams intramuscularly, was given every twelve hours. Blood cultures remained negative. Between August 14 and 23, the white cell count ranged from 1200 to 1400—all lymphocytes! On August 24, the leukocyte tally was 5,400 with a differential of 12 per cent polymorphonuclear cells, 73 per cent lymphocytes, 11 per cent bands, and 4 per cent monocytes. On this day the temperature became normal. The count improved rapidly over the next few days, and the patient was discharged on August 27, with a completely normal blood count.

A bone marrow study done during the acute phase of the disease yielded hypocellular smears consisting of fat globules, scattered normoblasts, lymphocytes, and an occasional megakaryocyte. No evidence of granulopoiesis could be found. Repeated lupus preparations were normal. Steroids were not used during the acute illness. The premature ventricular contractions disappeared during the febrile illness.

The patient has not been troubled since discharge (two years ago) with PVC's and none have been heard on auscultation or documented by EKG since this time.

The actual incidence of ectopic ventricular impulse formation is not known. Certainly, premature ventricular contractions occur both in healthy individuals and in persons with heart disease.[1] When heart disease is present, its diagnosis should be made on findings independent of the extrasystoles. Paroxysmal ventricular tachycardia in the absence of demonstrable heart disease has been reported.[2]

Ordinarily, reassurance and sedation suffices as therapy in persons with premature ventricular contractions if they have no demonstrable evidence of heart disease. On occasion this is not enough, and the anxiety becomes so great that the patient requires specific therapy to eliminate the premature contractions.

In individuals with demonstrable heart disease, anti-arrhythmia drugs are usually indicated when the diagnosis is made. Procainamide and quinidine sulfate are the most effective drugs in controlling premature ventricular contractions in patients whose extrasystoles are not caused by digitalis. Adverse reactions to quinidine are not uncommon and include skin rash[3], fever[4], thrombocytopenia[5], hemolytic anemia, anaphylactic shock, and agranulocytosis. Procainamide possesses its share of undesirable reactions. In addition to urticaria, gastrointestinal complaints, chills, fever and agranulocytosis, a lupus erythematosis-like syndrome has been seen by us on several occasions, and has been reported by others.[5, 6, 7, 8] When a patient is found to be hypersensitive to both quinidine and procainamide, and an effective anti-arrhythmia drug is necessary, the situation becomes serious. Diphenylhydantoin[9] is on occasion effective, but in our experience the high doses one must use, in non-induced digitalis ventricular arrhythmias for effective control, causes undesirable side reactions in spite of folic acid administration.

Propranolol hydrochloride had not been released by the Food and Drug Administration

Dosage Regimen for Desensitization of Procainamide with Methylprednisolone

Day	Methylprednisolone 7 am	12 Noon	5 pm	Procainamide 8:30 am	1:30 pm	6:30 pm
1	20 mg	20 mg	20 mg	25 mg	25 mg	25 mg
2	20 mg	20 mg	20 mg	50 mg	50 mg	50 mg
3	16 mg	16 mg	16 mg	75 mg	75 mg	75 mg
4.	16 mg	16 mg	16 mg	100 mg	100 mg	100 mg
5	12 mg	12 mg	12 mg	125 mg	125 mg	125 mg
6	8 mg	8 mg	8 mg	150 mg	150 mg	150 mg
7	8 mg	8 mg	8 mg	175 mg	175 mg	175 mg
8	8 mg	8 mg	8 mg	200 mg	200 mg	200 mg
9	4 mg	4 mg	4 mg	225 mg	225 mg	225 mg
10	4 mg	0 mg	0 mg	250 mg	250 mg	250 mg

at the time this patient was having his difficulties. Our experience to date with this drug in ventricular arrhythmias has not been extensive enough for us to comment on its use in ventricular premature contractions, although it is stated to be effective.

Rapid desensitization to the anti-tuberculous drugs, isonicotinic acid hydrozide (INH), and para-aminosalicylic acid (PAS), streptomycin, and viomycin, using steroids with gradually increasing doses of the offending drug has been accomplished with success on many occasions.[10, 11] Marth and Stallard[12] carried out successful desensitization to quinidine hypersensitivity, without ill effects in patients with fever, chills, and a morbilliform rash, by administering quinidine in small daily doses over several weeks until therapeutic doses were attained. They did not use steroids or attempt rapid desensitization. To our knowledge, rapid desensitization to either quinidine or procainamide has not been attempted, using steroids in a method similar to that used by Simpson *et al*[10] with INH and PAS. We chose to desensitize the patient rapidly to procainamide rather than quinidine since its adverse effects caused urticaria only, while quinidine had caused fever, chills, and transaminase changes.

Leukopenia and agranulocytosis are rare complications of procainamide therapy. When this toxic reaction occurs the mechanism would appear to be this. Procainamide is metabolized by a serum esterase[13] into para-aminobenzoic acid and diethylaminoethanol.[14] It is the benzine ring and benzamine structure which is an N-H-2 group (attached to the benzine ring), which are the precursors of the cause of the bone marrow depression.[15] In the metabolism and breakdown of the benzamine structure, orthoquinone and paraquinone result, and these end products are the important substances in the development of clinical agranulocytosis[16] rather than the intermediate product *per se*.

Desensitization was accomplished successfully in accordance with the protocol outlined in the table.

Agranulocytosis is considered to be produced as follows:[17, 18, 19] (a) Sensitization, (b) Granulopoietic shock with leucocyte tissue in bone marrow reacting as the shock organ, (c) Disappearance of granulocytes from circulating blood and tissue, (d) Development of necrotic areas and localized infection, (e) Bacteremia, (f) Overwhelming sepsis and death. The patient went through a, b, c, and d of the above, but e and f, were fortunately avoided.

In spite of the frequency of blood counts, the agranulocytosis, in this case, occurred without the warning of a gradually decreasing white blood count. The patient survived because the agranulocytosis was considered to be the cause of the patient's complaints; thus, he was hospitalized and the sensitizing agent was immediately withdrawn.

This case is instructive from several points of view. Desensitization to procainamide is possible, and, were it not for the complication of agranulocytosis, would have been very successful. Martt[12] accomplished desensitization to quinidine with no adverse long range effects,

and it is certainly conceivable that this might well be the case with procainamide in other situations. If desensitization is apparently accomplished, the patient must be followed carefully for a long time for adverse reactions; particularly bone marrow reactions when the drug is known to cause these. This patient did not develop difficulty until two and a half months after desensitization, and he was followed with weekly blood counts during this time. Patients so desensitized should be warned to report the least skin infection which does not heal, fever, or sore throat as soon as it occurs.

We did not use steroids in treating the patient's agranulocytosis and the patient did well. The granulocytes returned within nine days as had been predicted. When this occurred, the patient's temperature immediately returned to normal, and his feeling of well-being on this date was clinically evident before the blood count results returned.

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225 Williamson Street

Compulsory Contraception

In a recent address, AMA President Dorman said that "mandatory participation in birth control is repugnant to most Americans. For one thing, they resent compulsion in any phase of their lives. More importantly, that would interject the government between a man and his wife . . . and between a couple and their moral or religious beliefs.

Education, moral persuasion without compulsion, and the availability of counseling services seem to be the best mechanisms we have to carry out an effective program. In any event, any successful program must be carried out through joint efforts of many disciplines in the total health care team—physician, sociologists and social workers, public health and public welfare personnel, educators, economists, and the clergy. But whatever program is undertaken, the primary concern must be to respect the individual.

In this area, as in all others, we cannot sacrifice the individual for even what we know to be the good of society in the future. If the individual does not participate willingly in building it, then the society of the future won't be worth having.

Emulsion of mineral oil is here found to be safe, simple, and effective. Dr. Cohen considers and dismisses most of the objections raised against it.

Mineral Oil, Vitamin A, And Carotene*

Genesis And Correction Of A Common Misconception

Herman Cohen, M.D./Trenton

The problem of vitamin A supply in humans receiving mineral oil has been distorted by misunderstanding. Erroneous conceptions have been fostered by articles in magazines and newspapers, which have attributed many undesirable conditions to mineral oil. The purpose of this paper is to explore the background of this myth, and to evaluate the facts concerning mineral oil, its relationship to vitamin A, and its relationship to carotene.

Vitamin A is classified chemically as an alcohol.[1] It is derived from two sources, one of which is carotene. Carotene is a precursor of vitamin A.[2] Carotenes are yellow plant pigments which occur widely in the vegetable kingdom. They are found in high concentrations in yellow vegetables, yellow fruits and greens. Conversion of carotene to vitamin A occurs in the liver of healthy animals.[2] The liver acts also as a reservoir for the storage of vitamin A.[3] This source of vitamin A in the human is by the direct intake of carotene, through ingestion of the vegetables and fruits that contain it.

The second source of vitamin A is by the ingestion of animal products containing vitamin A derived from the animal's ingestion of carotene. Thus, cattle form vitamin A from carotene in their fodder and excrete it in milk. Hens form vitamin A from carotene in their food and excrete it in eggs. Fish livers contain large quantities of vitamin A formed from ingestion of carotene from marine algae. These animals store vitamin A in the liver and as a result, liver is a particularly lucrative source of the vitamin. From such animal products as milk, butter, eggs and fish liver oils, man derives the pure vitamin A in his diet.

The first reports on the subject appeared in the literature before 1929, at a time when the origin of vitamin A was unknown. At that time, Moore[2] pointed out that carotene from plant sources was responsible for the formation of a large portion of vitamin A. It is the impression of other investigators that carotene directly ingested in the human provides more vitamin A in the human than do the animal products. The average well balanced diet will provide a much greater quantity of the vitamin than the daily adult requirement of 4,000 U.S.P. units. Therefore, the vitamin A stored in the liver of persons having well balanced diets is always in abundance. Liver storage of the vitamin is such that individuals who have well balanced diets can ingest a diet poor in vitamin A for months before clinical evidence of deficiency appears.[4] The liver also regulates the amount of vitamin A which is released into the blood and is circulated to all parts of the body. The level of vitamin A in the blood is maintained within normal limits as long as the quantity of vitamin A in the liver remains adequate.

Vitamin A deficiency is manifested by degeneration of epithelial structures of the body.

* Read at the Northeast Proctologic Conference, November 1, 1969, at Atlantic City, New Jersey. Dr. Cohen is Director of Proctology, St. Francis Hospital, Trenton.

These changes may occur in the eye, with degeneration of normal epithelium and its replacement with keratinizing stratified squamous epithelium leading to the dryness and ulceration characteristic of xeropthalmia. Epithelial degeneration may also occur in the respiratory passages, urinary tract, the vagina, the nose, and the glands of the skin.[6,7]

Absorption of Carotene from the Intestine

Before 1939, investigations were on animals. The first investigation on humans was reported in 1939 by Curtis and Kline.[8] They fed human subjects diets containing varying concentrations of carotene, with and without mineral oil. They periodically measured the level of carotene in the blood. They found that when mineral oil was given simultaneously with food, it came into direct contact with the carotene. The carotene was absorbed by the mineral oil, and was evacuated with the stool. This decreased the blood level of carotene. However, when mineral oil was ingested when the stomach was empty, the mineral oil did not come into direct contact with the food. The carotene was not then absorbed by the mineral oil, instead, the carotene was absorbed into the blood stream in a normal or nearly normal manner. Curtis and Ballmer[9] found little or no difference in results whether a 65 per cent or 80 per cent emulsion of mineral oil was used. Other investigators substantiate these findings.

Absorption of Vitamin A from the Intestine

Moness and Christian,[10] in 1929, studied the effect on animals of cod liver oil and olive oil mixed with mineral oil. They observed that mineral oil did *not* interfere with the normal absorption of vitamin A. Rowntree,[11] in 1931 using cod liver oil as its source of vitamin A came to the same conclusion. Dutcher and his co-workers[12], in 1934, concluded from their investigation that the absorption of vitamin A contained in cod liver oil was unimpaired by the addition of mineral oil. Curtis and Horton,[13] in 1940, fed rats the mineral quantities of vitamin A necessary for normal growth. The rats grew equally well when fed vitamin A in mineral oil as they did when fed the vitamin without mineral oil.

Mahle and Patton,[14] in 1947, administered 30 cubic centimeters of mineral oil to human subjects daily at bed time for 51 days. The daily diet of the subjects contained 4,000 U.S.P. units of potential vitamin A. They found no evidence of an abnormal decrease in the plasma level of the vitamin.

A search of the literature on the subject of carotene and vitamin A absorption in the past 20 years has revealed only a scant literature on the subject.

Clinical Use of Mineral Oil

Mineral oil is a mixture of hydrocarbons obtained from petroleum.[15] It differs from organic oil inasmuch as it is not split by lipolytic enzymes and is not absorbed from the intestinal tract.[16] Mineral oil is not a laxative since it will not increase peristalsis. Mineral oil may aid in producing an evacuation, by lubricating rather than by stimulating peristalsis. Mineral oil is not irritating to the intestinal mucosa.[15]

The prime virtue of mineral oil is its stool softening property. The objective of a stool softener is to produce a smaller caliber lubricated stool consistent with easy passage through the anal canal without discomfort or trauma. Emulsion of mineral oil is particularly effective in this regard. The emulsion is in droplet form. The emulsion of mineral oil is produced with acacia or another suitable suspending agent, pleasantly flavored. These droplets mix more readily and thoroughly with the fecal matter before the stool forms, whereas plain oil may pool with a greater tendency toward seepage. (Figures 1 to 4)

Another virtue of the emulsion is that it can be mixed with water, fruit juice, or milk. This is usually the preferred method of administration by the patient. Dose must be adjusted on an individual basis. The recommended

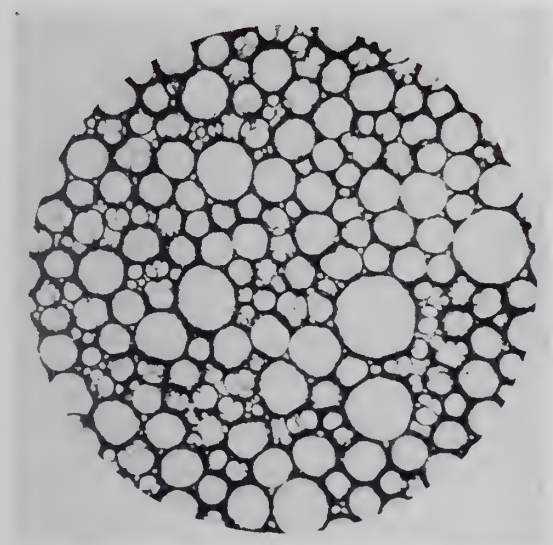


Figure 1—Microscopic view of mineral oil. Note the large globules.



Figure 2—Microscopic view of an emulsion of mineral oil (suspending agent Irish Moss). Note the small almost uniform globules.

starting dose is 15 cubic centimeters at bed time.

Stool softeners are particularly valuable for those who have the unfavorable tendency of absorbing an abnormally large quantity of liquid from the feces. This absorption results in a hard, dry, large caliber stool. This will usually cause straining at stool and tears in the anal canal which could produce pain and possible bleeding. If this condition persists early in life, it could produce hemorrhoids along with other ano-rectal pathology.

When the ano-rectal pathology develops, there is always less discomfort when evacuation is free and without straining. Bleeding from internal hemorrhoids may be controlled with a smaller caliber well lubricated stool. I am not suggesting that mineral oil will replace surgery or rubber band ligation where indicated, but merely that it is useful in pre-

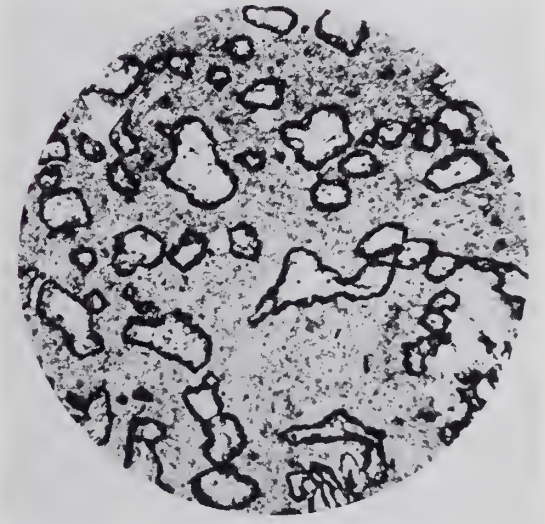


Figure 3—Microscopic view of mineral oil mixed with feces. The oil is easily identified.

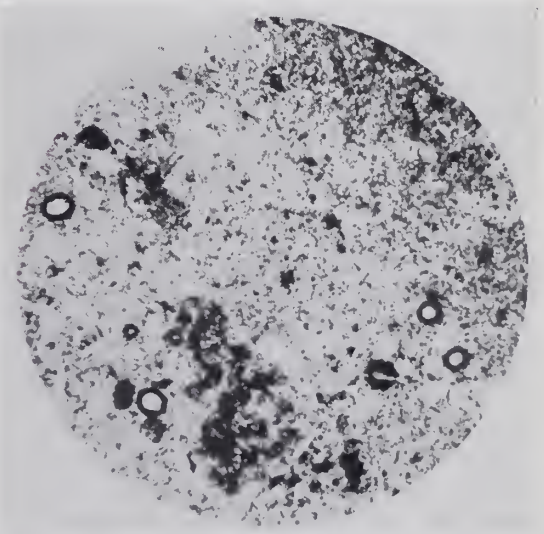


Figure 4—Microscopic view of an emulsion of mineral oil mixed with feces. The oil practically loses its identification.

venting aggravation with a possibility of controlling bleeding from the ano-rectal region.

Mineral oil may facilitate healing of superficial fissures. A superficial fissure cannot be expected to heal if the stool is of large caliber and produces continual trauma to the affected area. Of course supportive treatment is also imperative. A smaller caliber stool may reduce the discomfort in monilia excoriation of the anal canal. With the increasing use of oral antibiotics this condition is occurring with growing frequency. Individuals with frequent fecal impactions are often helped by a judicious use of mineral oil. It may prevent the impaction from forming by encouraging a more complete evacuation, and in those patients where it does not prevent the impaction, it will at least produce a softer stool that can be handled much easier than a hard cement-like mass.

Mineral oil is particularly valuable in postoperative ano-rectal cases. I prescribe the emulsion of mineral oil in practically all postoperative ano-rectal patients. The first dose is given on the second postoperative day and continued daily. I prefer that the patient have his first postoperative bowel movement on the fourth day. This usually facilitates the first postoperative bowel movement with minimum discomfort. Some assume that the stool is an effective dilator. I disagree with this, and regard the hard stool as more damaging than helpful. It also has been stated that mineral oil will prolong healing time.[16,17] This has not been my experience.

Continued use of mineral oil following surgery (where indicated) may be helpful in preventing recurrence of ano-rectal conditions, especially where the condition was produced originally by hard dry stools and straining.

Some object that mineral oil may stain the underwear. But many patients who have never used mineral oil stain their underwear with the expulsion of flatus. I actually surveyed patients taking the proper dose of an emulsion of mineral oil at bed time, and have found there is very little increase of staining. Staining attributable to mineral oil is small enough to be insignificant.

The literature[18,19] has reported aspiration of mineral oil into the lungs. I have never encountered this complication in forty years of practice. I am satisfied that, because of its rarity, it is insignificant. In the occasional patient, if the emulsion of mineral oil may not produce the desired results, other appropriate measures should be taken. There are available some emulsions of mineral oil containing laxatives which may be indicated and helpful.

Other undesirable conditions have sometimes been attributed to mineral oil. Most of these were in cases where the oil was given with no regard as to the time of intake, the quantity, or the type of oil prescribed, producing a liquid bowel movement and causing many of the hazardous effects associated with the liquid stool.[17,20]

Conclusion

Mineral oil, at bed time, when the stomach is empty or nearly empty, does not interfere with the absorption of either carotene or vitamin A. Under such circumstances both of these products are utilized in a normal or almost normal fashion. An emulsion of mineral oil is more desirable than the plain mineral oil, because of its greater tendency toward mixing more thoroughly with the fecal matter before the stool is formed, with less chance of seepage. The emulsion is usually preferred by the patient because it is easily mixed in fruit juice, milk, or water and has a pleasant taste. The benefits of the proper use of mineral oil far outweigh its shortcomings. There is also sufficient evidence to assure us that the prolonged proper use of mineral oil is practically harmless.

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1301 Hamilton Avenue

How To Get In Trouble With Your Narcotic Rx

The Federal Bureau of Narcotics has prepared *Dont's for the Practitioner* to protect him from narcotic addicts and abusers.

Don't leave prescription pads around; addicts may be forgers.

Don't write any prescription in lead pencil.

Don't write narcotics as "Morphine HT ½ # X" or "Morphine HT ¼ # 10." Several X's or zeroes can be added to raise the amount. Use brackets or spelling.

Don't carry a large stock of narcotics in your bag. Addicts often watch M.D.s' offices and cars.

Don't store your office narcotic supply unprotected, especially near a sink or washroom; patients may ask to use these facilities.

Don't fall for a story from a stranger claiming an ailment that usually requires morphine. The addict can produce blood sputum, simulate bad coughs or other symptoms. Make your own diagnosis.

Don't give an Rx to anyone except the actual patient. Addicts have posed as nurses.

Don't write for large quantities of narcotics unless unavoidable. Diversion to addicts is profitable.

Don't prescribe narcotics on the story that another physician has been doing so; consult that physician or hospital records.

Don't leave Rxs signed in blank for nurses to fill in; many have been stolen by addicts.

Don't treat an ambulatory addict. He may be going to several physicians at one time.

Don't dispense narcotics without keeping records, although bedside and office administration is permissible.

Don't buy your office narcotic needs on an Rx blank. The law requires that you use an official order form.

Don't resent a pharmacist's call for verification of an Rx. He is held responsible if forgeries are filled.

Don't hesitate to call an agent of the Federal Bureau of Narcotics (at your nearest Federal Building) or the Narcotics Division of your State Department of Health if the patient is suspect. Your information will be held in strict confidence.

Do not phone in a *Class A Narcotic* prescription except in true emergencies; even then, the pharmacist must have a written prescription in his or his agent's hand before he can make delivery to your patient. The pharmacist or his agent may pick up the prescription at your office or at the home before making delivery.

Violations of this section of the narcotic law may get you two to ten years imprisonment and a $20,000 fine for the first offense.

This is the only reported case of anaphlyactic reaction to iron-dextran after a negative test dose.

Iron-Dextran Anaphylaxis

Occurrence After A Negative Test Dose

Paul Lewinter, M.D./Scotch Plains

The intramuscular administration of iron-dextran (Imferon)® is a relatively safe manner of administering iron to patients unable to tolerate or respond to oral iron therapy. However, untoward effects have been reported, the most serious of which is anaphylactic reaction. To detect patients who may be sensitive to iron-dextran, the administration of a small test dose prior to therapy is recommended. Ability to tolerate such test dose is taken as an indication that the patient is *not* sensitive to the compound. This paper reports a patient who had a non-fatal anaphylactic reaction following a negative test dose of Imferon,® and suggests that the test dose itself may have been responsible for sensitizing the patient to iron-dextran.

A sixty-one year old woman had a six-year history of ulcerative colitis. This had been diagnosed by sigmoidoscopy, rectal biopsy, and barium enema. She was admitted to the hospital for the first time due to a severe exacerbation of the illness manifested by diarrhea, melena, and cramping abdominal pain. The patient was pallid, in moderate discomfort with a rectal temperature of 101. Diffuse abdominal tenderness and hyperactive bowel sounds were present. Physical examination was otherwise unremarkable.

On admission the hemoglobin was 10.1 and hematocrit 30 per cent. Red cells were hypochromic. The white count and differential were within normal limits and the reticulocyte count was 4 per cent. Electrolytes, B.U.N., blood sugar, urinalysis, V.D.R.L., chest x-ray, and electrocardiogram were either negative or within normal limits. Sigmoidoscopy and barium enema demonstrated ulcerative colitis. Serum iron was 73 and iron-binding capacity was 194. The patient was treated with diphenoxylate,[13] salicylazosulfapyridine,[14] intravenous A.C.T.H., low residue diet, and phenobarbital. On this regimen the diarrhea was controlled with the patient having three or four soft, lightly blood-tinged stools daily, without significant abdominal distress. She became afebrile and felt generally well. She was discharged on Azulfidine,® phenobarbital, low residue diet, and ferrous sulfate to be taken with meals. On discharge the hemoglobin was 9.8 and hematocrit was 28.

She was seen as an outpatient following her discharge at weekly intervals, and continued to do well with the exception of a progressively falling hemoglobin and hematocrit. After one month of oral iron therapy her hemoglobin was 8.5 and her hematocrit 25. In view of the inability of oral iron to maintain her hemoglobin level a one cubic-centimeter test dose of iron-dextran[12] was administered to the outer upper quadrant of the buttock. Care was taken to ascertain that the material did not enter the vein. The patient tolerated this well and was seen again one week later, at which time she denied any symptoms after the test dose. Consequently 5 cubic centimeters of iron-dextran[12] were administered by deep intramuscular injection into the upper outer quadrant of the right buttock. Again, care was taken to ascertain that the injection was not administered intravenously. Four minutes following the injection, she complained of severe shortness of breath, nausea, light-headedness, pain in the area of her thoracic spine, and constriction of the chest. She became pallid, diaphoretic, vomited, and involuntarily passed a large, bloody stool. She complained of the urge to defecate and urinate. Pulse became thready at a rate of 140. Blood pressure was ascertained as 50 by palpitation, and was not obtainable by auscultation. Half a cubic centimeter of epinephrine was administered subcutaneously and half that dose was given intravenously. Hydrocortisone was also administered intravenously. She did not sneeze, wheeze, nor break out in a rash. These measures afforded partial relief of her symptomatology and she was transferred by ambulance to the hospital.

Upon arrival, the receiving physician, noting that she was in a shock-like state, began an intravenous infusion of dextran for the purpose of intravascular volume expansion. After a few drops of the dextran was administered the patient complained of severe chest pain, back pain, abdominal cramping, and shortness of breath. This was stopped immediately and 0.25 cubic centimeters of epinephrine 1 to 1000 was administered intravenously. Also given were hydrocortisone sodium succinate[15] plus oxygen by positive pressure mask. These afforded the patient partial relief of her symptoms. Subsequent hospital course was one of gradual clearing of the anaphylaxis. On discharge, she exhibited no manifestations referable to the anaphylactic episode.

Although iron-dextran, in use since 1957, is a relatively safe preparation for parenteral administration, a variety of untoward effects may be associated with it. The most serious is anaphylactic shock.[1 to 6] At least four cases of fatal anaphylaxis have been associated with the administration of iron-dextran,[12] two of which have been published.[7,8,9] The presumed mechanism is hypersensitivity to dextran,[5] and this patient's prompt exhibition of the symp-

toms of anaphylaxis after the inadvertent administration of dextran supports this thesis.

Sensitization to dextran may occur by means other than exposure in a therapeutic experience. Dextran is a natural product found in some confections and beer. It is produced by the action of chain-forming cocci on sucrose. It is capable of antigenic stimulation, with antibody formation as a result of previous contact with microorganisms. To detect dextran-sensitive patients, skin testing is of no worth[10] and consequently the use of a small test dose is the currently recommended method. However, if the patient is sufficiently sensitive to dextran, even the small test dose may produce a reaction. One death has been reported[7] following a small test dose. An alternative preparation, iron-sorbitol citric acid complex has been used for intramuscular injection with success with little or no antigenicity because of its low average molecular weight. However, some preparations of iron-sorbitol appear to supply some iron in more available ionized form (as citrate) which may give rise to the cardiovascular side-effects characteristic of ionized iron if the transferrin capacity of the serum is exceeded. This preparation seems to be more painful than iron-dextran when injected intramuscularly. With the sorbitol, a variable amount of the injected iron may be excreted in the urine making the calculation dose requirement difficult and possibly aggravating any existing urinary infection. Consequently, neither should be given unless oral iron administration is clearly not feasible, a point having been repeatedly emphasized in the literature.[11]

This case is unique in that it is the only reported instance of an anaphylactic reaction having occurred after the administration of a negative test dose. In fact, the sequence of events strongly suggests that the patient was sensitized by the test dose itself. Although the one cubic centimeter test dose administered was larger than the manufacturer's recommended test dose (a half cubic centimeter), it would appear that some patients, particularly those with diseases conceived to be immune or auto-immune in nature (for example rheumatoid arthritis and ulcerative colitis), may develop hypersensitivity more easily than one would otherwise expect.[8] This case is reported to alert the physician to the fact that a negative test dose does not guarantee that the patient will not have an anaphylactic reaction. Moreover, it is possible that the test dose itself, as well as subsequent therapeutic doses, may sensitize the patient to iron-dextran. It also re-emphasizes the need to limit parenteral iron administration to those patients who have iron deficiency anemia and who cannot tolerate or will not respond to oral iron.

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12. Imferon® is an iron-dextran prepared by Lakeside Laboratories of Milwaukee.

13. Diphenoxylate hydrochloride is available under the Searle tradename of Lomotil.®

14. Salicyl Azosulfapyridine is tradenamed Azulsulfadine® by the Pharmacia Laboratories of Piscataway, New Jersey

15. The hydrocortison sodium succinate was administered as Solu-Cortef® (Upjohn)

567 Park Avenue

If we have to depend on great university medical centers for renal transplants, we will never have enough facilities. Community hospitals with the manpower and mechanical equipment to do so should be prepared for such procedures.

Renal Transplantation In A Community Hospital

Hossein Eslami, M.D.;
Victor Parsonnet, M.D.; et al*/Newark

In the United States, an estimated 7,000 patients with end stage renal disease will be candidates for renal transplantation annually. Some 99 centers throughout the world, of which 44 are in the United States, participate in this program.[1] A simple comparison of the number of candidates for renal transplantation and the centers equipped to perform and care for these patients makes it obvious that handling this case load is beyond the capacity of existing facilities. One solution to this problem is the participation of community hospitals in renal transplantation programs.

It is appropriate, therefore, to report our experience from the Newark Beth Israel Medical Center, a teaching community hospital, to those individuals and centers interested in establishing a Renal Transplantation Unit.

The success of a renal transplantation program requires:

1. An active hemodialysis service to provide pre- and post-transplantation care and maintain a pool of patients eligible for renal transplantation.

2. Full-time qualified personnel to supervise and direct the clinical work.

3. Consultants in immunology, psychiatry, pathology, and hematology.

4. Fully equipped laboratories for tissue typing, chemical and blood gas determinations, and hematologic studies.

5. A cooperative and understanding hospital administration.

The first clinical renal transplant in the United States was in December 1954. Through 1967, 1,741 cases had been reported and documented in the Kidney Transplantation Registry. Transplant survival varies according to the donor source—namely, sibling, parent, or cadaver, as shown in Table I. The best results are obtained when the donor is a sibling.

Table I

Sixth Report of Human Kidney Transplant Registry (1741) 1 year survival of transplant

Donor	Sibling	Parent	Cadaver
Over-all—1741	68%	62%	35%
Before Jan. 1, '66 1005	60%	56%	27%
After Jan. 1, '66 736	78%	71%	45%

(The table shows one year survival of the *transplant*: since many patients have survived the rejection and removal of their transplanted kidney, the *patient's* survival is much higher than transplant survival.)

* In addition to Dr. Eslami and Dr. Parsonnet, the authors include the following nine physicians: Joseph Alpert, M.D.; Sheldon Schoen, M.D.; Seymour Ribot, M.D.; Martin Jacobs, M.D.; Lester Goldman, M.D.; B. W. Lee, M.D.; Emmanuel C. Morales, M.D.; K. Venkata Raman, M.D.; T. Gopalrao, M.D.; and Libertad Nazareno, M.D. The authors here acknowledge the technical assistance of Mrs. Lillian Robinson and Mrs. Goldie Hampel. Doctors Morales, Raman, and Gopalrao are holders of the Max Danzis Fellowship in Surgery. Doctor Nazareno is the hospital's Fellow in Renology. The Renal Transplantation Group is at the Newark Beth Israel Medical Center and includes members of the Departments of Surgery, Medicine, and Laboratories. This project was supported in part by grants from the Vascular Research Section and the Research Institute of the Beth Israel Medical Center.

Currently, renal transplantation is well established as a therapeutic procedure that should be offered to selected patients in end-stage renal disease.[1]

Organization

In our transplantation team, the members included a full-time surgeon, two vascular surgeons, a urologist, nephrologist, immunologist, pathologist, fellows, nurses, and the hemodialysis department. The technical and administrative procedures of other transplant centers throughout the country were meticulously evaluated by visits to their units. Concurrently, experimental transplantation in the animal laboratory was begun, and each member of the team was required to function as he would during an actual human transplantation procedure.

Selection of the recipient follows the criteria generally accepted by other transplantation centers. The recipient should have end-stage renal disease, but should be free of other life threatening disease and infection. The lower urinary tract should be normal as confirmed by cystography and cystoscopy. Although an age limit of 45 years is usually observed, the age *per se* should not be an absolute limiting factor.

The donor can be a living person, related or unrelated (free kidney) or a cadaver. The living donor is evaluated physically and psychologically. Once accepted, a more detailed medical work-up is done on an out-patient basis. Blood and leukocyte typing is given special emphasis. Donors without the minimal "C" match are excluded (an "A" match is found only in identical twins, a "B" match is only minimal discrepancy in tissue typing, and so on. "A" and "B" matches are rare, and most transplantations done in the past have been "C" matches.) Final studies are carried out in the hospital, and include an intravenous pyelogram, aortogram for visualization of the external and internal renal vasculature, cystoscopy, and retrograde pyelography when indicated.

The recipients of *cadaver* kidney transplants are selected from the many patients being sustained by hemodialysis. The cadaver donor should be below 60 years of age, and preferably below 55. There should be no history of previous renal disease, urinary tract infection, metabolic disorders, malignancy (other than brain), or communicable diseases.

The Harvard criteria[2] for death of the donor are generally accepted. The largest number of suitable cadaver kidneys come from patients with extensive brain injury. After the patient is pronounced dead by *two physicians who are not members of the transplantation team,* generally on the basis of electroencephalogram, ventilation and circulation are maintained by artificial means until the recipient is prepared for surgery. In cadaver kidney transplantation, the recipient preoperative preparation of necessity is very short and immunosuppressive drugs are started concommitant with the operation.

On the other hand, preparation of the recipient of a kidney from a living donor starts five days prior to the selected date for surgery. The patient is admitted to an isolation room and Imuran®, 2 to 3 milligrams per kilogram of body weight per day, is given. Anemia is corrected by transfusion. Hemodialysis is done the day before surgery with special attention to ultra-filtration to achieve maximal tissue dehydration.

The scope of the transplantation procedure, the possibilities of success and failure, and the dangers are frankly discussed with the donor and recipient alone and then at a combined session.

The donor is hospitalized one day prior to surgery and prepared as for a routine nephrectomy. Two adjacent operating rooms are selected for kidney transplantation. The donor kidney, upon removal, is immediately immersed in Ringer's solution at 4°C, and transferred to the recipient's room where it is perfused with Ringer's solution containing 50 milligrams of heparin and 100 milligrams of procaine per liter. The renal vein is then anastomosed end-to-side to the iliac vein, the

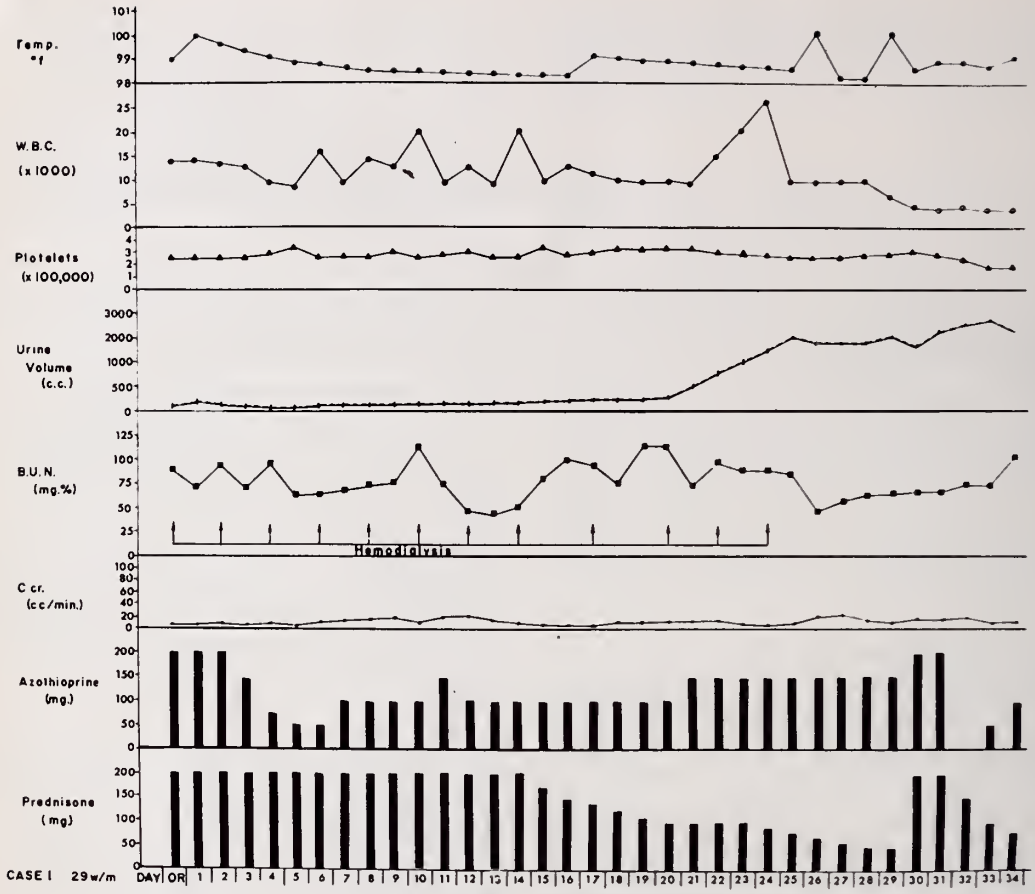


Figure 1—Case One—Details of post-transplantation course.

renal artery end-to-end to the divided internal iliac artery, and the ureter is implanted in the bladder through a submucosal tunnel without using an internal splint. The bladder is closed in three layers, and a Foley catheter is inserted in the urethra. No cystostomy catheter is used. A Hemovac® catheter or Penrose drain is left in the retroperitoneal perinephric space and the wound is closed.

Postoperatively the recipients are isolated in a specially constructed room which is rendered "germ free" by positive pressure laminar filtered air flowing downwards from the entire ceiling. The patient remains in this room until the wounds are healed. Special nurses are provided and physicians are in constant attendance until the patient's condition stabilizes. Isolation technics are scrupulously followed by all contacts.

The immunosuppressive drugs used currently are Imuran©, prednisone, and ALG†. Daily laboratory determinations are recorded on a flow sheet. Dialysis may or may not be required in the postoperative period depending upon how rapidly and well the kidney functions. After discharge from the hospital the patient is followed weekly in the Transplantation Clinic.

Case One

A 29 year old male was in apparent good health until the end of 1967 when he experienced intermittent headaches and malaise. In January 1968, hematuria occurred and investigation revealed impaired renal function due to chronic glomerulonephritis. Medication and diet had to be supplemented with hemodialysis.

By March 1968, he was on home hemodialysis. Living donors were unavailable and cadaver transplantation was thoroughly discussed with the patient and his family.

In September 1968, a cadaver kidney became available. The donor was a 59 year old female who had died of brain injuries. The blood type of the donor

†Antilymphocyte globulin

was the same as the recipient but *retrospective* leukocyte typing showed only a "D" match. The recipient's kidneys had been previously removed.

The donor's left kidney was transplanted in the right iliac fossa of the recipient. The operation was uneventful and urine formation was immediate. However, acute tubular necrosis occurred 24 hours later, and anuria developed. He was treated daily with 75 to 200 milligrams of Imuran® and 200 milligrams of prednisone. Hemodialysis was continued three times weekly. A radioisotope renogram and renal scan revealed patent major circulation but no excretory phase.

On the 17th postoperative day, renal function resumed. The urinary output was 233 cubic centimeters for the first 24 hours and by the 31st day this had increased to 3100 cubic centimeters (Figure 1). The blood urea nitrogen fell gradually to 50 milligrams per cent. The patient's condition improved. After the 24th postoperative day hemodialysis was discontinued.

On the 26th and on the 31st day a transient rise in temperature was noted. Hematuria was discovered, but the urinary output remained in the range of 2000 to 3000 cubic centimeters per day. No source of infection could be demonstrated. There was no abdominal or rectal tenderness at the transplantation site. Pyuria, however, suggested an early urinary tract infection. On being treated with Keflin® and Kanamycin®, the fever subsided but the pyuria persisted. On the 37th postoperative day, cystoscopy revealed hemorrhagic cystitis, and a deep ulcer in the area of the ureteroneocystostomy. A cystogram demonstrated pressure on the right side of the bladder but no dye extravasation. This suggested a collection of fluid around the transplanted kidney, and nephrectomy was recommended. This was rejected by the patient who requested an extension of medical treatment. Two days later he deteriorated suddenly, and he died on his 43rd postoperative day.

At autopsy a large perinephric abscess cavity was found. It communicated with the bladder adjacent to the ureteroneocystostomy.

Case Two

A 35 year old male was in apparent good health until 6 years prior to admission when he was found to have a hydronephrotic left kidney due to an aberrant renal artery compressing the ureter. The vessel was then transected. Subsequently, he developed hypertension and the clinical picture of chronic glomerulonephritis. By June 1968 he was no longer responsive to medical management and peritoneal dialysis and subsequent hemodialysis were instituted.

The patient's sister was found to be a compatible donor. Their blood types were AB positive, and leukocyte typing was almost a perfect match as shown on Table II. An intravenous urogram showed questionable mild hydronephrosis of the donor's right kidney

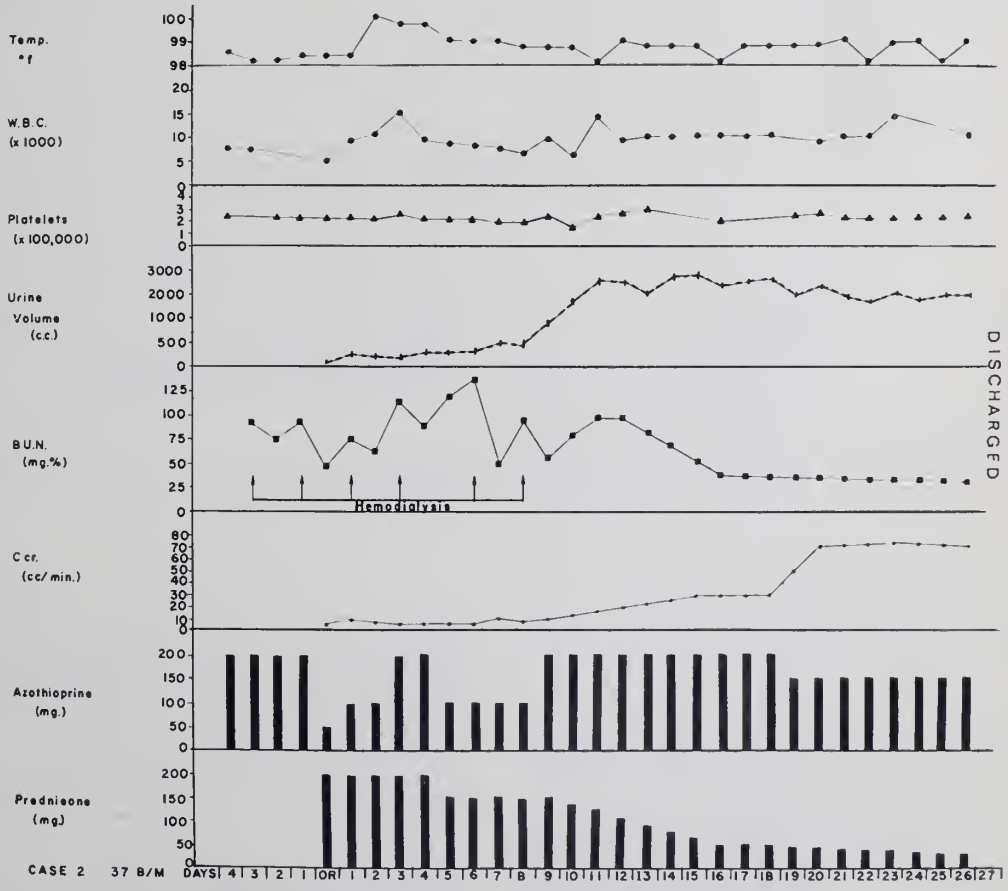


Figure 2—Case Two—Details of post-transplantation course.

and a normal left kidney. An aortogram demonstrated single renal arteries bilaterally. There was no clinical evidence of urinary infection. The right kidney of the donor was selected for transplantation.

Table II

WH				
4 (A— B—)	6B—	7C—	7D+	LA (1— 2+ 3—)
Donor				
4 (A— B—)	6B—	7C—	7D+	LA (1— 2+ 3—)

On September 25, 1968, a bilateral nephrectomy was done on the recipient, and the right kidney of the donor was transplanted to the left iliac fossa of the recipient. Immediately after transplantation the patient put out some urine, but the output dropped to zero the day after transplantation. Imuran® and prednisone were given and gradually decreased to 20 milligrams of prednisone a day by the time of discharge.

Hemodialysis was carried out three times postoperatively and on the 9th day the urinary output was 886 cubic centimeters which increased thereafter to 2000 and 3500 cubic centimeters a day. The BUN dropped precipitously to 19 milligrams per cent. The Creatinine clearance rose to 80 cubic centimeters per minute. All wounds healed well and the patient was discharged on the 27th postoperative day on maintenance prednisone and Imuran®. The patient returned to work as a school teacher after 8 months and remains well after one year.

Case Three

A 37 year old female had received a cadaver kidney from a 56 year old female who had a massive subarachnoid hemorrhage on November 19, 1968. Previous bilateral nephrectomy had been performed on the recipient. After an immediate urinary output of approximately two liters in the first one and a half hours, acute tubular necrosis occurred necessitating postoperative hemodialysis. On the sixth postoperative day, immediately after a hemodialysis, a massive perinephric hematoma was surgically evacuated, but no active localized bleeding was found. Five days later the hematoma recurred, again shortly after dialysis, which required re-exploration and evacuation. No obvious point of bleeding could be found. Since both incidents happened immediately after hemodialysis, (although protamine was given in the venous line) heparin was thought to be the contributing factor. After the second exploration, the wound became infected. Nevertheless, the kidney function improved and on December 17, 1968, there was a urinary output of 535 cubic centimeters (Figure III). Fever, oral moniliasis, and focal pulmonary infiltration due to septic emboli occurred and necessitated the omission of immuno-suppressive drugs and an eventual nephrectomy.

Since all available extremity vessels had been used previously, it was impossible to reconstruct a suitable shunt for hemodialysis. She was maintained on peri-

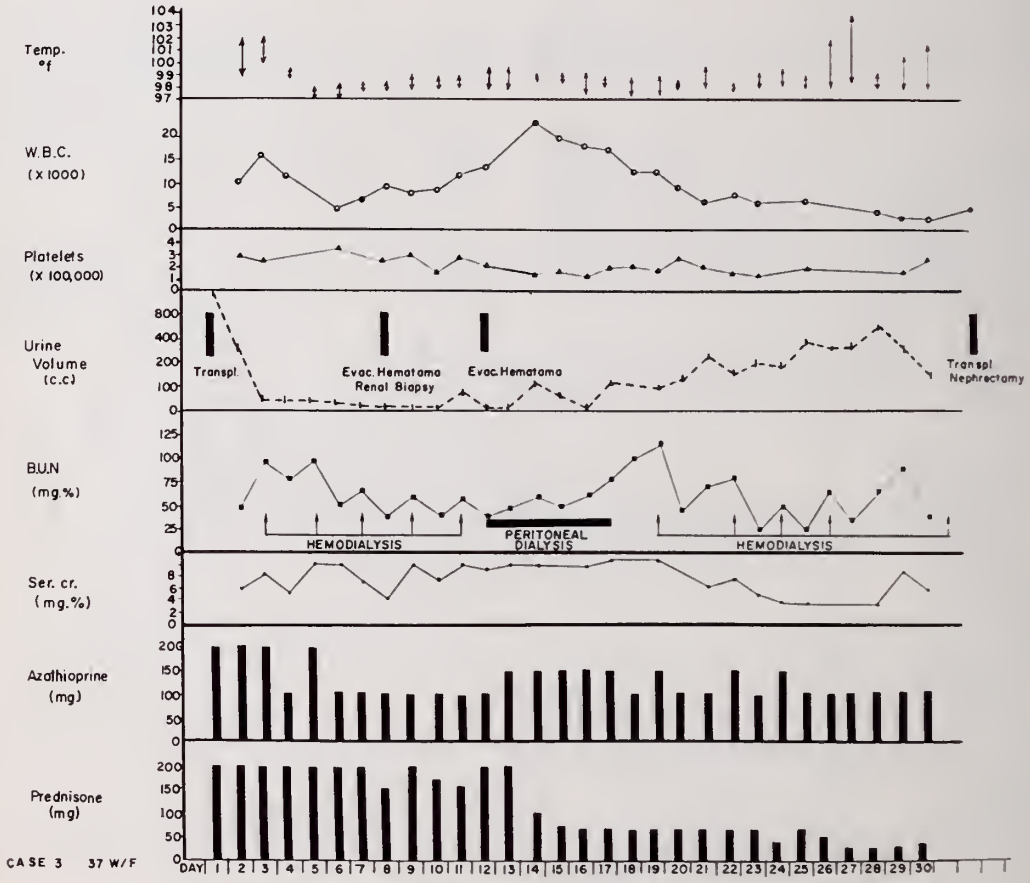


Figure 3—Case Three—Details of post-transplantation course.

toneal dialysis for a short period and finally died on March 11, 1969.

Case Four

An 18 year old female with renal insufficiency due to glomerulonephritis was treated medically for one year following which a program of hemodialysis was started. The mother was found to be a good match and satisfactory as a future donor. Transplantation had to be postponed in order to control a urinary tract infection in the recipient. Bilateral nephrectomy was finally done on June 12, 1969, and one month later she received her mother's left kidney.

Renal function commenced immediately and hemodialysis was not required. With decreasing amounts of immunosuppressive drugs there was a slight temperature rise on the 18th postoperative day with signs of minor rejection. Although the immunosuppressive drugs were increased, signs of a major rejection became apparent and anuria occurred. Hemodialysis was reinstituted. Treatment was supplemented with ALG† and the transplant site was irradiated. Kidney function gradually resumed. Her BUN dropped to 34 milligrams per cent and the serum creatinine to 2 milligrams per cent. The urinary output was more than two liters per day. Immunosuppression was continued with Imuran®, prednisone and ALG†.

Case Five

A 33 year old male was treated at another hospital by peritoneal dialysis for renal insufficiency. Hemodialysis was instituted at the Newark Beth Israel Medical Center and the patient trained for home dialysis. He had a compatible brother. Urologic evaluation of the recipient demonstrated vesical neck contracture and bladder trabeculations. Wide resection of the posterior bladder neck was done.

The patient was admitted to the hospital on July 30, 1969. On August 5, 1969, a bilateral nephrectomy was done and he received his brother's right kidney. Postoperatively, the urinary output was adequate but gradually decreased so that hemodialysis was required before sufficient kidney function returned. On the 16th postoperative day the patient complained of lower abdominal pain and a mass at the kidney transplantation site was noticed. The next day, temperature rose to 102.4 and the mass became larger. Needle aspiration revealed serosanguineous fluid, and subsequently a large non-purulent hematoma was evacuated. Following evacuation his temperature returned to normal. The immunosuppressive drug requirements were minimal and excellent kidney function has been maintained.

Discussion

The most essential requirement of a kidney transplantation program is an active hemodialysis center to care for a significant number of patients with end-stage kidney disease, and to provide hemodialysis in the post-transplantation period if necessary.

In 1961, the Newark Beth Israel Medical Center embarked upon a program of hemodialysis for acute renal failure and drug poisoning.[3] The home hemodialysis program began in January 1966. The pressing needs of the community were such that enlargement of the chronic hemodialysis program became mandatory. We now have five hospital hemodialysis spaces, plus two additional spaces in the intensive care unit. These are staffed by two nephrologists, one resident, nine nurses, and two technicians. Although patients generally have accepted and adjusted well to hemodialysis, the need for a transplantation program was obvious.

Many patients express a desire for elective transplantation, although some prefer continuous hemodialysis. However, in the latter, cannula failures that deplete the number of sites for new cannula insertion are a continuous problem. Consequently, these and other patients with related living donors present themselves for transplantation as the preferred treatment. The expense of dialysis in time, money, personnel, and emotional stress force others to seek transplantation. All these considerations plus the steady growth of our patient volume, stimulated the inception of our allotransplantation program in September 1968.

The problem of renal transplantation in man is multidisciplined and involves the departments of Surgery, Urology, Medicine, Immunology, and Laboratory Medicine. An endocrinologist, radiotherapist, and dedicated nurses are also important. The participating nurses were selected from the Intensive Care Unit, and were trained by visits to other transplantation centers, lectures delivered by physicians of our renal transplantation team, and on-the-job training. Finally, but not least, the dedication and understanding of the hospital administration was invaluable in supporting this costly program.

It has been shown that the results of leukocyte typing correlate well with graft survival and success.[4, 5, 6, 7] (The most widely used indicators of tissue compatibility between donor and recipient are leukocyte typing and crossmatching.) We have established a tissue typing

† Antilymphocyte globulin

laboratory under the supervision of the Department of Laboratories, staffed by a technician trained at the New York Blood Center and by Dr. P. Terasaki in Los Angeles. The technician performs tissue typing and crossmatching in conjunction with the attending pathologist.

The selection criteria for acceptance to the hemodialysis program also apply to the transplantation program, so that in case of transplant failure there will be room for these patients in the hemodialysis center. The prolonged wait for cadaver kidney transplantation can be offset by maintaining the patient on home dialysis.

Home dialysis is accomplished with a Kiil®-type dialyzer with a Drake Willock® delivery system or a Travenol® RSP dialyzer. Total dialysis time varies between 24 to 30 hours per week divided into two to three dialysis periods. In-hospital dialysis is performed with Kiil-type dialyzers or Travenol ultra-flow 145′ coil.

Our Case One demonstrates that infection is the *bête-noir* of organ transplantation. Once infection starts, vigorous efforts to save the patient by any means short of transplant nephrectomy usually fail. Of interest is the emotional reaction of both the treating physicians and the patient toward the transplanted kidney. After transplantation, the patient, having invested so much in the outcome of surgery, is reluctant to have a functioning kidney removed and to accept the failure. The intense desire to save the transplanted kidney by any other possible means is understandable but unacceptable, since the usual result of this unfortunate combination is loss of life. Although these problems are well recognized, a constant alert for infection and its localization may not yield the source until too late.

Summary

The experience of the renal transplantation unit of the Newark Beth Israel Medical Center, a teaching community hospital, is described. Kidney transplantation has passed well beyond the experimental stage, and is now an accepted modality for the treatment of patients with end-stage renal disease.

Rigid criteria for both the recipient's and donor's protection must be adhered to before undertaking the task of transplantation.

Five cases are reported which emphasize the importance of the medical and administrative team effort, and verify that renal transplantation can be successfully performed at the community hospital level. Of the five transplantations reported, three are alive and well.

A comparison of the number of candidates for renal transplantation with the existing capacity of the transplantation centers shows that hospitals with a well planned and administered renal program should participate in this discipline. Only in this manner can the needs of the community be satisfied.

Addendum

Since this manuscript was prepared, a sixth transplant was performed on September 5, 1969. The patient was a 38 year old male with glomerulonephritis and tertiary hyperparathyroidism for which he had a seven-eighths parathyroidectomy and bilateral nephrectomy in preparation for renal transplantation. A cadaver kidney with a "C" match functioned well on the 9th postoperative day following a transient period of shutdown. At the present time (January, 1970) the patient is doing well. He has been discharged from the hospital, and has returned to work.

Thus, four of the six patients with transplants are alive, including one of three patients with a cadaver kidney, and all three patients with a kidney from a related living donor.

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201 Lyons Avenue

Massive gastrointestinal bleeding is usually fatal in the newborn. Here are two cases where swift surgery was effective.

Bleeding Neonatal Duodenal Ulcer*

Successful Surgical Treatment of Two Cases

Peter J. Guthorn, M.D.; Anthony P. De Spirito, M.D.; Joseph E. Raffetto, M.D.; and Urie A. Parkhill, M.D./Neptune City

Acute massive gastrointestinal hemorrhage in the newborn is an emergency requiring prompt and often aggressive management. Duodenal ulcer must be considered a likely cause.

Neonatal ulcer was reported first by Cruveilher[1] as far back as 1829. An extensive review was published by Bird, Limper, and Mayer[2] in 1942. Other reports[3 to 24] and reviews have been published since, all indicating the exceedingly high mortality. Thompson and Jewett[20] reported that the only survivors among six bleeding patients of ages one to fourteen days were the two treated surgically. Raffensberger, *et al*[24], also reported four patients with two survivals treated by vagectomy and pyloroplasty

These two cases are being reported because of their rarity, features of management, and successful outcome under treatment in a community medical center.

Case One

A full term male infant was born on New Year's Eve. Birth weight was 7 pounds, 6 ounces. Delivery was normal. The color was good and initial examination negative.

The mother was 22 years of age, para II, gravida III, both previous deliveries at 34 weeks. Mother and infant were rH negative. At 3 a.m., on January 1, a small amount of mixed dark and bright blood was passed per rectum. Within the next three hours there were passages of large amounts of slightly altered blood by rectum with hematemesis on one occasion. There was a very marked drop in blood count and noticeable pallor. Coomb's test was negative, serum bilirubin was normal, prothrombin time was within normal limits, platelet count was 150,000. The infant was seen by a pediatrician for the first time and given Vitamin "K" oxide and 30 cubic centimeters of whole blood by umbilical vein. The condition remained good but later in the morning there was another episode of hematemesis and rectal passage of bright blood. In an attempt to determine the site of bleeding, a small naso-gastric tube was passed.

The bright blood and coffee ground material in the gastric contents implicated the upper gastrointestinal tract as the source of bleeding. Continued severe bleeding, in spite of blood replacement, confirmed the joint opinion of pediatrician and surgeon that laparotomy was indicated immediately.

Thirty additional cubic centimeters of blood were started at 30 hours of age. Laparotomy was carried out through a right paramedian incision. Large amounts of blood were noted in the colon and entire small intestine. Gastrotomy revealed old and fresh blood. Fresh blood was noted entering the stomach through the pylorus. A minute examination was then made of the duodenum. This demonstrated a slightly hyperemic, thinned-out appearing area in the anterior wall of the second portion. A longitudinal incision was made and the walls everted. A small loosely adherent clot was found on the under side of the thinned out area, which when dislodged produced active arterial bleeding. The area was excised and bleeding vessels ligated. Further search and aspiration revealed no other active bleeding point. The duodenotomy incision was closed transversely. The immediate post-operative condition was excellent. The specimen submitted to the pathologist showed an area of necrosis and acute inflammation, consistent with acute duodenal ulcer. The post-operative course was not remarkable except for a superficial wound infection due to Staphlococcus albus. X-ray series on January 20 demonstrated a deformity of the duodenal bulb. The infant was discharged on the twenty-third day weighing 7 pounds 3 ounces.

Subsequent development has been normal. There have been no digestive complaints. When seen at the age of 4½, his weight was 56 pounds and height 51½ inches.

* This work is from the Surgical and Pediatric Services, Jersey Shore Medical Center, Fitkin Hospital, Neptune, New Jersey.

Case Two

A full term female infant was born on April 18. Birth weight was 5 pounds, 1 ounce. Delivery was normal and general examination negative. The mother was 29 years of age, para I, gravida II. A previous pregnancy five years before resulted in a premature birth with death due to prematurity. Mother and infant were rH positive. Four normal meconium stools were passed on April 19 and 20; but at 1 p.m. on April 20, at the age of 48 hours, a large bloody stool was noted. A naso-gastric tube was passed; suction produced blood stained material. Several additional large bloody stools were passed to the time of surgical consultation early on the morning of April 21.

At birth, hemoglobin was 20 grams. This dropped to 14 Grams by 4 p.m. of the second day. Forty cubic centimeters of whole blood were then administered into the umbilical vein. Further bloody stools were passed and naso-gastric tube suction produced bloody fluid in spite of blood replacement.

The joint opinion of surgeon and pediatrician was for immediate laparotomy following administration of additional whole blood. The tentative diagnosis was a bleeding ulcer based upon our previous case.

Laparotomy was carried out through a right paramedian incision. Large amounts of blood were noted in the entire colon and small intestine. A small area of the inferior free portion of the duodenum was different in appearance from that surrounding. The duodenum was incised longitudinally and the area of altered duodenal mucosa was excised in several segments until only grossly normal mucosa was left. The defect was closed transversely. The immediate post-operative condition of the patient was excellent.

The specimen showed an area of epithelial replacement by an intense, granulocytic infiltrate with an area of denudation. Adjacent, the mucosa was markedly hemorrhagic with distended vessels in the sub-mucosa. Other sections showed intense mucosal congestion and hemorrhage.

The remainder of the post-operative course was not remarkable. The baby was discharged on the seventeenth post-operative day. She weighed 4 pounds, 15 ounces. Just one year later, she weighed 19 pounds. There had been no digestive disturbances and development was completely normal.

Bleeding may arise anywhere in the baby's intestinal tract; or it may represent ingested maternal blood. The Apt Test[21] for maternal hemoglobin is useful in differentiating. If there is no evidence of diminishing blood volume, in spite of melena, the blood has probably been ingested.

Passage of a naso-gastric tube may indicate that the bleeding is from the upper gastrointestinal tract. If no blood is noted, nasopharyngeal examination and proctoscopy should be done. In the meantime, a platelet count, prothrombin time, Coomb's test, and so on, are recommended.

Lost blood volume should be replaced in increments of 30 to 50 cubic centimeters. Vitamin "K" oxide may be administered. A convenient method of blood administration is by the umbilical vein, into which a small polyethylene catheter is threaded. Repeated transfusions can be given intermittently, the catheter being withdrawn, then reinserted as needed.

Indication for laparotomy is the continuation of bleeding in the absence of an obvious nonsurgical cause.

Scout films of the chest and abdomen are done if perforation is suspected. Gastrointestinal x-ray studies are of questionable value in the face of continued significant blood loss.

A right paramedian incision gives excellent exposure. Careful gross examination of the undisturbed viscera (without manipulative trauma) is followed by meticulous, orderly, methodical "threading" of the entire intestinal tract. If blood is seen through the stomach wall, longitudinal gastrotomy just proximal to the pylorus is carried out with careful lavage of the interior. Small cotton pledgets are of use in manipulation and eversion of the distant parts of the stomach. Rough application of forceps to the exterior of the viscera may induce misleading areas of mucosal alteration of hemorrhage. Finally, the surgery should be directed to the immediate control of the source of bleeding and restoration of gastrointestinal continuity, without alteration of physiology.

Summary and Comment

Two cases of massive neonatal bleeding due to duodenal ulcer have been presented with an outline of management. A notable feature of both was the very slight gross abnormality or appearance of the bleeding point. In the case described by Hollander[5] the ulcer was not noted until the fixed specimen was examined. Presented also is an outline of management, the principal features of which are careful preliminary observation, frequent hematocrit and hemoglobin determinations, pro-

thrombin determination, blood replacement by umbilical vein, early laparotomy in the fact of continued bleeding, extremely careful examination of the viscera for the cause of bleeding at operation and limitation of the surgical procedure toward control of the immediate problem of hemorrhage. As the etiology is obscure, procedures altering the physiology such as gastrectomy or vagectomy are not warranted.

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2100 Corlies Avenue

New Brochure About Cigarettes

Why do 49 million Americans continue to endanger their health by smoking, despite persuasive evidence linking cigarette smoking with cancer, heart attacks, strokes, and respiratory diseases? What can be done about it?

These two questions are discussed concisely in *Cigarettes—America's No. 1 Public Health Problem* by Maxwell S. Stewart. This new public affairs pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue, South, New York 10016. By now, the harmful effects of smoking seem undeniable, and millions of people do periodically try to quit. About two million a year now succeeed in doing so, but their place is taken by just as many new young smokers, including children. Today, youngsters are being "induced to show their 'maturity' by experimenting with this 'adult' practice." The hazards of smoking add up to a public health problem against which there is no vaccine.

Stewart summarizes efforts to lessen the health hazards, and suggests that action has been hampered by political conflicts between tobacco interests and congressional representatives from tobacco-growing states on the one side, and medical and health professions and more independent Congressmen on the other.

In addition to public measures, Stewart underscores the need for redoubled efforts to persuade young people not to start smoking and confirmed smokers "to make a substantial effort to break the cigarette habit."

Dr. Freymuth is Director of our State's Drug Addiction Treatment Center. The following material is presented for the guidance of our members. Because methadone is itself an addicting drug, the private practitioner should scrupulously observe the cautions here suggested.

Methadone And The Private Practitioner

Hans W. Freymuth, M.D./Trenton

Methadone hydrochloride (Dolophine, Amidone, Adanon, Phenadone, Althose) is an opiate-type narcotic drug with analgesic effects similar to those of morphine and is classed by Bonica and Allen* as a "synthetic compound with a structural resemblance to the morphine molecule." It is a potent pain-killing drug and can induce withdrawal effects if stopped after the patient develops a tolerance to it. Unlike most other narcotics, it is highly effective when taken orally and is relatively long-acting, its action lasting from 12 to 48 hours depending on the dose. Because of its addicting properties, its use in the treatment of addicts must be carefully supervised.

What is the usefulness of methadone in the treatment of addiction?

The two major therapeutic indications are different from each other and must be carefully separated for legal as well as medical reasons.

One is *detoxification* of an individual addicted to heroin, morphine, or other opiate-like drugs. Here, the goal is to help the patient to "kick the habit," meaning giving up the regular use of his addictive drug by temporary replacement of the addicting opiate, mostly heroin, with *decreasing* doses of methadone over a *short* period of time with the purpose of avoiding or minimizing physical withdrawal symptoms and signs. Indication for this treatment is predominantly a humane one, because withdrawal from heroin or morphine, while subjectively quite disagreeable, is rarely, if ever, dangerous. However, this disagreeableness is serious enough to present frequently a deterrent against giving up of an established habit.

Opiate withdrawal symptoms and signs include anorexia, lacrimation, rhinorrhea, sneezing, increasing perspiration, yawning, or restlessness.

More serious withdrawal signs consist of tremors, dilated pupils, goose flesh, muscle twitches, abdominal and leg cramps, back pains, insomnia, increasing restlessness, elevated pulse rate, temperature and blood pressure, nausea, vomiting, and diarrhea.

Detoxification is a relatively simple procedure, but it should preferably be performed in an in-patient facility to assure strict control of the patient. Unfortunately, few hospitals are willing to do this, and therefore, the private practitioner is frequently approached by heroin addicts with a request for ambulatory detoxification.

The following detoxification schedule is suggested for ambulatory detoxification:

First Day: 25 mgms. of methadone in form of Dolophine®, which is supplied in 5 and 10 mgm. tablets. The first day's supply should be divided into two doses. The first consists of 15 mgms. to be taken in the pres-

*Bonica, J. and Allen, G. in *Drugs of Choice 1969*, edited by Walter Modell, M.D., St. Louis, Mosby. Page 193.

ence of the physician. He takes home one 10 mgm. tablet to be taken 8 to 12 hours later.

Second Day: Same as first day.

Third Day: A total of 20 mgms. in divided doses of 10 mgms. each, the first dose to be taken in the physician's presence, the second 8 to 12 hours later.

Fourth Day: 10 mgms. in one single dose to be taken in the physician's presence.

Fifth Day: 5 mgms. to be taken in the physician's presence.

This schedule is generally sufficient to abolish or minimize withdrawal symptoms. If necessary, it may be modified in accordance with the patient's needs, but it should never extend beyond nine days. Do *not* exceed a total daily dose of 25 mgms. because it is difficult, if not impossible, to obtain reliable information from addicts concerning their habit, and giving higher doses on the assumption that the patient has a heavy habit and therefore high cross-tolerance to methadone is potentially dangerous and opens the door to manipulations by the addict.

Under no circumstances should the patient receive one single prescription covering the entire amount needed for his detoxification schedule. Methadone can be used as a "pump primer," thereby enabling the addict to produce the euphorizing effect of heroin with smaller amounts than normally needed. Methadone tablets have already obtained considerable black market value and there is evidence of a thriving business in the sale and exchange of the tablets among addicts. Without these precautions, you may be unwittingly contributing to the illegal methadone traffic.

An entirely different indication is continuing replacement therapy in the form of methadone maintenance. This requires specialized skills and facilities and should *not* be undertaken by the private physician. Recognition of this fact has been recently expressed by the Food and Drug Administration identifying methadone (Dolophine®), used for maintenance, as a *new and experimental drug*, thereby limiting its use for this purpose to physicians in possession of an IND (Certificate of Investigator, New Drug). Under this new regulation, you may *not* prescribe methadone (Dolophine®) legally for maintenance purposes, but may continue to do so for detoxification and for the relief of pain.

Methadone maintenance appears to be the treatment of choice for opiate addicts whose addiction has been in existence for one year or more. The pattern of addiction follows certain laws. The early addict takes his "shot" because it gives pleasure in the form of a "high," a euphoric state which gives him a brief escape from a reality often perceived as miserable, bleak, or boring. He takes his drug for affirmative reasons. After one or two years of addiction, the picture gradually changes. Heroin loses its positive effect, and by this time, the addict's life is more and more dominated by fear of withdrawal pains and a strong and generally irresistible craving for the drug without clearly definable reason or goal. The pleasure element has become minimal or absent.

When an addict has reached this stage, methadone maintenance often becomes an extremely rewarding form of treatment. If given in daily doses (the amount of which has to be established on an individual basis ranging from 60 to 200 mgms.) the addict's craving for heroin ceases. In fact, the methadone maintained addict, once the proper maintenance dose has been reached, is highly refractory to the effect of heroin or other opiates because of cross tolerance. On the other hand, the protracted effect of methadone does not allow for the development of an euphoric state, nor does it lead to withdrawal symptoms. Addicts successfully established on methadone maintenance have a feeling of well-being, show normal moods, normal alertness and wakefulness, and normal sleep patterns. Having been freed of their craving, they are often capable of successfully re-integrating into normal life. Statistics on close to 80 hard-core addicts collected by us over the past two years and now living in their communities on methadone maintenance, are testifying to this fact.

Methadone maintenance consists of three

phases: (1) Induction; (2) Maintenance; (3) Withdrawal.

The first phase has to be carried out in an in-patient facility to keep the addict under full control. Failure to do so leads, in a great number of instances, to a mixed addiction because the addict, during the build-up phase on methadone which is gradual and extends over approximately three weeks, continues using heroin and leaves the use of methadone as a pump primer. He can do so because only after he has been established on *full* maintenance dose, does he become refractory to the effect of heroin. Proper determination of the right maintenance dose has to be based on close observation of the patient's reaction pattern during build-up, which is not possible if he has access to other drugs. The induction phase requires hospitalization from three to five weeks.

The second or maintenance phase consists of daily visits to a clinic where the addict takes his maintenance dose, which remains constant once it has been established, in the presence of a professional person permitted by law to administer a Class A Narcotic, i.e. physician, registered nurse, or pharmacist. On each visit the patient is required to give a urine sample, which is then processed for examination by a urine monitoring laboratory for detection of possible use of other drugs, such as barbiturates or amphetamines. He has to keep a close time schedule so that medication is taken at fairly regular 24 hour intervals. Finally, successful rehabilitation of an addict on methadone maintenance depends on close follow-up, counseling, and support to be provided by a trained social worker. Psychiatric intervention might be needed for some of these patients. The entire program has to be under medical supervision. The demands of such a program are hardly within the scope of a private physician's resources and should be left to specially equipped and staffed clinics.

The third phase remains an unresolved problem. We do not know yet when and how to break the methadone habit of a maintenance patient. It is something to think about, but there are reasons to hope that eventually ways will be found to accomplish this goal.

Summary

The private practitioner can help by providing, with the use of methadone, judicious detoxification procedures. Detoxification is a much needed service, even though it often affords only temporary relief to the addict.

For legal and medical reasons, the private physician should avoid getting involved in methadone maintenance procedures.

433 Bellevue Avenue

Short Term Training For Laboratory Workers

The National Communicable Disease Center is compiling a list of organizations which offer short-term training for persons in clinical and public health laboratories. Academic training for full-time students will not be included. The completed list will be made available to all persons interested in continuing education for medical laboratory personnel. The compilation will help alert training coordinators, supervisors, and prospective students to many little-known sources of short-term training, some at no cost to the student.

Companies, professional associations, individuals, and schools which provide such training should write to: the National Communicable Disease Center, attention of Mr. John H. Krickel, Laboratory Division, Atlanta, Georgia 30333. No information will be included in the published list without prior clearance from the organization or individual offering the training.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

January 18, 1970

A regular meeting of the Board of Trustees was held on January 18, 1970 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Medicaid Payments for Hospital Clinic Services . . . Received the following clarification submitted by the Director of the Division of Medical Assistance, Department of Institutions and Agencies, of Section 202.5 of the *Physicians' Manual* which states that all services rendered in the hospital clinic setting are considered hospital costs, including physicians' services.

"Practitioners services provided to eligible persons who are registered in the outpatient department (institutional clinic) are reimbursable only as an institutional cost, and only when the hospital is under obligation to pay the practitioner for such services.

"When a practitioner renders service in a hospital outpatient setting to a person as his private patient, reimbursement for such service may be made to the practitioner.

"I trust this will overcome the concerns which were referred to you in this area of medical assistance administration."

Conference on Comprehensive Child Care . . . Approved cosponsorship (with no financial commitment) with the New Jersey Public Health Association of a Conference on Comprehensive Child Care to be held in North Brunswick on April 22, 1970.

AMA Congress on Medical Education . . . Authorized the attendance (with expenses paid) of Dr. Morris H. Saffron (Chairman of MSNJ's Committee on Medical Education) at the AMA Congress on Medical Education to be held in Chicago, February 8 and 9, 1970.

AMA Conference of Mental Health Representatives . . . Authorized the attendance (with expenses paid) of Dr. Robert S. Garber (Chairman of the Council on Mental Health) as MSNJ official representative at the AMA Conference of State Mental Health Representatives to be held in Chicago, March 13 and 14, 1970.

Medical Defense and Insurance . . . Approved the following recommendations (as amended by the Board) of the Committee on Medical Defense and Insurance:

1. That the Board of Trustees authorize the E. and W. Blanksteen Agency to begin marketing the Extended Term-Life Insurance Policy.

NOTE: The extended Term-Life Insurance Program would be available not only to member-physicians, but to spouse, dependent children, and employees, on an individual basis—the member physician need not be insured under this policy. The policy is convertible to permanent life at any time up to age 70.

2. That the Board of Trustees approve a conference meeting to be held between representatives of the Council on Legislation and representatives of the Committee on Medical Defense and Insurance to evaluate the suggestions submitted by the Joseph A. Britton Agency to lessen the number of malpractice claims under the Professional Liability Insurance Program.

NOTE: The above recommendation resulted from correspondence from the Middlesex County Medical Society concerning rising rates for malpractice insurance.

3. That if, after the suggested conference, it is concluded that certain suggestions have merit, with the concurrence and approval of the Board, they be submitted to Judge Alexander Waugh for possible further consideration and action by the Conference Committee with the Bench and Bar, and the Supreme Court Committee on Relations with the Medical Profession.

4. That all members of MSNJ be canvassed and requested (on a form to be supplied to them) to report to the Committee on Medical Defense and Insurance, for statistical purposes, any claims or settled cases against them since January 1, 1965, whether protected at the time of the incident by MSNJ's official carrier or some other; and that they be requested in the future, as soon as a claim has been made against them, no matter who the carrier may be, to submit this information to the Committee.

5. That the proposed rate increase (for professional liability insurance) be approved by the Board of Trustees, effective May 1, 1970 for new enrollees, and as of the regular renewal date (November 1, 1970) for all present policy holders.

NOTE: An increase of 15% in the base rate and an increase in the excess limits factors of 25% for non-surgical and 50% for surgical.

6. That the following changes in classes and rules under the Professional Liability Program be approved by the Board:

a. Class 6 rate is 60% of class 1 rate. Class 6 is for physicians retired and pharmaceutical or insurance company employees. The rate will be increased to 75% of class 1 rate and retired physicans will be moved from class 6 to class 7.

b. Establish a new class 7 with rate of 50% of class 1 rate.

c. Move from class 1 to class 6 the physicians whose specialties are physiatry, preventive medicine, psychiatry, public health, and rehabilitation.

d. Move from class 1 to class 2 the specialties of radiology and roentgenology.

e. Move from class 4 to class 5 the specialty of plastic surgery.

f. Reduce the charge for x-ray therapy by dermatologists from 75% of class 1 rate to 50% of class 1 rate.

g. Reduce the charge for x-ray therapy, other than by dermatologists, from 100% of class 1 rate to 75% of class 1 rate.

h. Reduce the charge for electroconvulsive therapy from class 2 rate to class 1 rate which is a 33% reduction.

Committee on Medical Education . . . Approved the following recommendation of the Committee on Medical Education:

That the Board of Trustees of The Medical Society of New Jersey strongly urge every member to participate in the AMA Recognition Award Program.

NOTE: After the Presidential Commission on Medical Manpower recommended periodic re-examination for licensure, the AMA (February 1969) announced it would grant a recognition award to each physician who offered documented proof of 150 hours of participation in continuing medical education every three years.

Committee on Environmental Health . . . Approved the following amended recommendation from the Committee on Environmental Health:

That MSNJ record itself as strongly urging that a moratorium be declared on any future development on the Master Plan prepared by the Hackensack Meadowlands Development Commission until ecologists can be consulted, who would provide a long-range view of all facets of the problems involved. A revised master plan should then be prepared incorporating their suggestions.

Project Hope and Vietnam . . . Approved the recommendation of the Committee on Project Hope and Vietnam for the granting of a $1,000 fellowship to Frank Colantuono, M.D. (Bergen County) for a tour of duty with the *S.S. Hope* to Tunisia, January 15 to March 15.

. . . Authorized the Chairman of the Committee on Project Hope and Vietnam and the Executive Director to review the regulations governing Project Hope Fellowships, and (if not in contravention of requirements) to approve the request of Dr. John J. Flanagan (Monmouth County), who recently completed a tour with the *S.S. Hope*, to donate his fellowship grant to Project Hope, The People-to-People Health Foundation.

Pension Plan . . . Directed that the Special Committee on Pension Plan (for employees of MSNJ) be authorized to negotiate with Mr. O'Connor (of the firm of Kruse, O'Connor and Ling, Inc.) in establishing a new Pension Plan for the employees of the Society along the lines contained in the Committee's minutes which stated that the current plan was a sound and generous one at the time of its adoption, but that it does not provide adequately for economic changes which have progressively taken place.

. . . Directed that MSNJ compensate Mr. O'Connor for the work to be entailed in the effectuation of the new Pension Plan and for the annual services to be rendered, on the basis of estimates which he submitted in a letter dated January 12, 1970.

Board of Medical Examiners . . . Nominated the following, in the order of preference indicated, to fill the vacancy on the Board of Medical Examiners upon the expiration February 10, 1970 of the term of Dr. John J. McGuire of Newark:

John J. McGuire, M.D., Newark
Isaac N. Patterson, M.D., Westville
I. Edward Ornaf, M.D., Camden

New Jersey's Delegation to the AMA . . . Directed that in the future alternate delegate representation at the AMA meetings be as follows: Meetings east of the Mississippi—7; Meetings west of the Mississippi—3.

Officers' Hospitality Suite . . . Designated Dr. Edward G. Bourns of Westfield to assist Dr. Garrison in hosting the Officers' hospitality suite at the 1970 Annual Meeting.

Medicaid Payments for Private Patients . . . Adopted the following statement concerning Medicaid payments for beneficiaries seen as private patients, and directed that a copy of the action be sent to the Director of the Division of Medical Assistance and Health Services of the Department of Institutions and Agencies:

The Board re-emphasizes the basic principle that all Medicaid patients should be treated as private patients whether they are seen in the hospital out-patient department or otherwheres, that the service rendered should be supplied by a licensed physician, and that reimbursement for such service should be on a fee for service basis.

Conference of Presidents . . . Empowered the President and Chairman of the Board to name the Trustee representative for the morning session of the Conference of Presidents and Presidents-Elect of Component Societies on February 15 at the Executive Offices.

Proposed Amendments to the Bylaws . . . Approved the following proposed amendments to the Bylaws and directed that they be referred to the Secretary of the Society for processing in accordance with Chapter XII of the Bylaws:

Chapter II — Meetings
Section 3 — Rules of Order

Current	*Proposed*
The deliberations of this Society shall be governed by parliamentary usage as contained in Roberts' "Rules of Order, Revised." when not in conflict with the Constitution and Bylaws.	The deliberations of this Society shall be governed by parliamentary usage as contained in *Sturgis' "Standard Code of Parliamentary Procedure,"* when not in conflict with the Constitution and Bylaws.

Chapter V — Procedure of Election
Section 1 — Nominating Committee

Current	*Proposed*
(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the Nominating Committee. This committee shall meet in the evening of the first day of the annual meeting and report the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled, including Trustees, elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations.	(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the Nominating Committee. This committee shall meet *at a convenient time proximately prior to the opening session of the House of Delegates* and report the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled, including Trustees, elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, Delegates and Alternate Delegates to other medical organizations.

Chapter V — Procedure of Election
Section 3 — Report and Election

Current	*Proposed*
(d) When a member who already holds an elective office is elected to a second office, the presiding officer shall then declare the previous elective office vacant. This vacancy shall then he filled immediately by nomination from the floor and election by the House of Delegates.	(d) *When an incumbent elected officer, as defined in Article IV, Section 3 of the Constitution, is elected to serve as an officer in another capacity,* the presiding officer shall then declare the previous elective office vacant. This vacancy shall then be filled immediately by nomination from the floor and election by the House of Delegates.

Chapter VII — Judicial Council
Section 4 — Duties of the Judicial Council

Current	*Proposed*
4. To receive complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate county judicial committee;	4. To receive *inquiries,* complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate county judicial committee;

AMA Planning and Development Reports . . . Empowered the President to appoint a special committee to study and evaluate, and make constructive recommendations concerning the majority and minority reports of the AMA Committee on Planning and Development presented to the AMA House of Delegates at the Clinical Convention in November (1969).

. . . Directed that 21 extra copies of the reports be obtained, to be sent to each of the component societies for study and recommendations to this newly established MSNJ committee, indicating an appropriate deadline.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Disease during January, 1970:

	1970 January	1969 January
Aseptic Meningitis	13	2
Primary Encephalitis	2	1
Post-Infectious Encephalitis	0	0
Hepatitis: Total	253	141
Infectious	201	122
Serum	52	19
Malaria		
Military	13	0
Civilian	4	1
Meningococcal Meningitis	7	19
Mumps	337	176
German Measles	70	26
Measles	305	58
Salmonella	47	10
Shigella	35	0

Influenza

Data as of January 30, 1970 indicate that influenza activity in New Jersey thus far this winter has not been excessive. Three small outbreaks of influenza A2/Hong Kong/68 have been confirmed by the Laboratory Division of the New Jersey State Department of Health. The first was in Parlin (Middlesex County) in which an increased incidence of upper respiratory illness was seen. The other two were in Cranford (Union County) and in Pequannock (Morris County). In both Pequannock and Cranford, there was excessive school absence. However, mortality reports from 48 major municipalities in New Jersey have *not* indicated significant increases in over-all mortality in the state; nor has there been excessive mortality from pneumonia. These parameters constitute two indirect indicies of influenza activity. Throughout the period January 19 to 30, additional scattered areas reported excessive school absenteeism (15 per cent or more) due to upper respiratory illness. These include one or two schools each in Sussex, Monmouth, Bergen, Union, and Morris Counties. There have been no reports of unusual industrial absenteeism, however.

Despite the widespread occurrence of influenza of the Hong Kong variety in Europe this winter, the United States Public Health Service has predicted little activity in the United States. Isolated outbreaks have occurred in small communities in Vermont, in Hartford, Connecticut, in a small area of Baltimore, and in communities in Alaska. Sporadic serologic conversions and/or isolations have been documented in New Hampshire, New York, North Carolina, Florida, Michigan, New Mexico, Colorado, Oregon, and Hawaii. The curves for pneumonia-influenza deaths in 122 United States cities have demonstrated an elevation above the expected frequency for the nation as a whole during the first three weeks of January. (*Morbidity and Mortality Weekly Report* 19:14 Jan. 17, 1970). The United States Public Health Service feels that the influenza outbreak in the United States last winter produced a high level immunity in the population, and speculates that the current mortality elevations represent unrecognized influenza activity, involving groups that had little exposure to the influenza virus last winter.

A rather uniform clinical syndrome has been noted in the outbreaks in New Jersey. The symptoms most commonly encountered have been fever, chills, sore throat, cough, and myalgias. Headache and nausea have been reported in some instances.

Erratum

In Doctor Arthur Winter's article, "Death and the Road Back," page 670 of the December 1969 (Volume 66, No. 12) issue of *The Journal*, we should have included this acknowledgment:

The image drawings here shown were made by the patient under the direction of Leo Shatin, Ph.D., a psychologist in the Department of Psychiatry at the New Jersey College of Medicine and Dentistry.



News From NJCMD

With the exception of pollution and the threat to ecology, few subjects have attracted the sustained interest of the news media, the profession, and the public in recent years as has the whole question of narcotics and drug abuse.

New Jersey presents a sad picture. Fifth in the nation in addiction incidence, the state is eighth in the number of heroin users. The City of Newark itself is considered by many to be "the heroin center of the United States." Police estimate there are more than 3,000 addicts in Newark, a ratio of 1 to 130 as compared to the national estimate of from 1 to 2000 or 4000. More than a third of the state's addicts are in Newark. The Garden State has *the greatest numerical increase in addicts in the nation.* A glance at the daily papers shows the threat is very real in the suburban and rural areas as well.

Against these awesome facts, arrayed in scattered and disorganized defense, have been several small service units. These include:

DARE—Drug Addiction Rehabilitation Enterprises, a residential community which accepts addicts in its participants.

Integrity—A "halfway" house concept for former addicts which helps them adjust to social realities to aid them in avoiding a return to narcotics. This is a live-in arrangement.

Mount Carmel Guild—An out-patient clinic for addicts sponsored by the Catholic Church.

Odyssey House—A therapeutic community operated on a residential basis, stressing the psychiatric approach for the addict. Operated by the well known Odyssey House in New York.

The New Well—An outpatient clinic, storefront arrangement, which is a voluntary, independent organization.

New Jersey Regional Drug Abuse Agency—The home for addicts at Liberty Park, funded by the Office of Economic Opportunity (OEO).

Drug Addiction Treatment Center—Within the Neuro-Psychiatric Institute at Princeton. This is a state operated inpatient facility which uses the much discussed methadone maintenance method.

A prime problem has been lack of coordination of these groups and their programs and results. Each offered a different therapy. Many, in the early phases of their organization, were understaffed and underfunded. There was no system of inter-referral, sharing of clinical information, nor continuity of care, even for addicts moving from one undertaking to another.

The New Jersey College of Medicine and Dentistry asked its Department of Public Health and Preventive Medicine to study this problem and recommend changes. The result is the Department's Division of Drug Abuse, already operating out of temporary quarters in the College's Martland Hospital in Newark. In several short months, the Division has developed a comprehensive program which brings together the small service units into a joint effort, funded by a federal NIMH grant of $2,225,000 over five years.

Thus, all the approaches are offered under one program, and a medical school has an

opportunity to evaluate the effectiveness of each approach. A cardinal feature is continuity of care, assuring that patients move through treatment and into different facilities according to their needs and rate of progress. Your College provides leadership from a singular position, as the only medical school where the Division of Drug Abuse is a major component of a teaching department.

The program has several basic objects. First, to medically detoxify the addict and assess his medical, psychological, social, vocational, and other needs. The project directors (qualified physicians) then refer the addict to a variety of treatment programs. Continuing research into the results of the program and its various parts enables the Division of Drug Abuse to develop new programs and pass on its finding on the efficacy of existing ones.

The College will train health professions in various programs, show medical students the factors affecting drug abuse, and educate teachers and other school personnel in order to develop school curriculum from kindergarten through high school, aimed at stemming the rising tide of drug abuse. NJCMD is developing a broad spectrum of programs for the dissemination of written, audio-visual, and other material and equipment for many publics.

A key to the entire program will be the development and maintenance of a confidential registry of narcotics addicts, used in the same completely confidential manner and for the same purposes as, for instance, the Public Health Service's Registry of Communicable Diseases.

The Division of Drug Abuse will, upon request, send a brochure describing the entire program, suitable for your use or for distribution to your patients, interested organizations, and the like. Printed in a bright, attractive color, it fits into a regular envelope. For information get in touch with Mr. Lee R. Munsick, Director of Professional Relations, NJCMD. Phone (201) 877-4373 or write to 36 Commerce Street, Newark 07102.

Doctors' Incomes And New IRS Rulings

The Internal Revenue Service postponed until January 1971, a new requirement that health insurance companies report to the IRS payments of $600 or more a year to a physician.

The delayed provision covers payments other than under medicare and medicaid. Payments of $600 or more under these government programs are already being reported to the IRS.

The IRS regulation applies only to direct payments to physicians. The Senate added an amendment to an omnibus tax bill that would have extended the requirement to indirect payments also. But House-Senate conferees took out the amendment. However, Congress did pass an amendment which gives approval to an IRS ruling that advertising revenue of medical tax-exempt organizations is subject to the regular corporate income tax. *The Journal* of The Medical Society of New Jersey and all state medical journals and *JAMA* itself are thus affected.

Dr. Thompson Goes To Viet Nam

A group of twelve American physicians, left San Francisco on New Year's Eve, thus bringing the total of tours of duty by participants in the AMA-administered Volunteer Physicians for Viet Nam Program to exactly 700 since its inception in 1965.

Those who forsook the Christmas holidays with their families in order to serve 60 days in South Viet Namese provincial hospitals included John J. Thompson, of Essex Falls, New Jersey, an Essex County radiologist. These physicians, in exchange for their professional services, receive only their transportation and a $10 daily expense allowance.

Peer Review

The following is abstracted from a talk by Richard S. Wilbur, M.D., Assistant Executive Vice President of the American Medical Association, before the Council of New England Medical Societies in Providence on November 15, 1969, and published in the January 1970 issue of the Rhode Island Medical Journal.

The phrase "peer review" means to us a survey of a physician's work by other physicians. One reason we are asked to do this is that the government must be assured that it is getting its money's worth for all the billions it has spent with these large programs. No man can be elected to public office on a platform in which he agrees to allow the expenditure of unlimited and unchecked sums of money for any purpose—even for the health care of the American people. All of us are taxpayers and would like to think that the money we give up to our government is buying something worthwhile. The non-physicians of the country have been convinced by what they read in the newspapers that they are no longer getting their money's worth for taxes spent on Medicare and Medicaid. They want, rightfully, some proof.

Malpractice protection is another factor. This is an ever-growing problem in some areas, such as Southern California where premiums of 5 to 16 thousand dollars a year are now being paid by doctors who have never been sued. Over and over the point is made that the public is not assured that medical care is of high quality. Therefore, the allegations of the plaintiff's attorney fall upon open ears and juries are willing to believe the worst about all physicians. If they knew that an adequate mechanism of peer review existed which assured them of the quality of health care this problem could be alleviated as it has been in areas such as Tucson, Arizona.

Then, too, the press has been willing to assign the responsibility for all of the rise in health care costs to the physician although it includes the vast portion which is paid to institutions, particularly the hospitals and extended care facilities. If physicians are to take the blame for the expense, the least we can do is to take the responsibility for supervising the expenditure.

Most important, however, is the need for satisfying the American people that they are receiving the highest possible quality of care.

Is there any precedent for doctors, in their organizations, to engage in review of the quality of health care? There certainly is! The AMA, since its inception, has been opposed to low standards as exemplified by quacks and chiropractors. Even before the Flexner Report, and certainly very much since then, we have been concerned with the quality of training in medical schools and with the accreditation of internship and residency programs. We have worked to improve the quality of drugs since 1900.

Within the local medical societies there have been rather elementary forms of peer review for many years. Most societies have some form of insurance review committee. This committee adjudicates fees and makes some effort to explain why the fine print in an insurance contract means that the company does not have to pay the patient for the physician's work. Most societies also have grievance committees. These take care of complaints. Both committees are largely of the brush-fire type, i.e., they do not go into action until long after a problem has occurred and not until after someone else brings it to the attention of the medical society.

As reviewers (albeit as peers) what are we really looking for? First, is it fraud, which in medicine is no different from any other kind of fraud, and the duty of the peer review team is no different than that of any other honest citizen? This is rare and soon taken out of the hands of the physicians. The next item for which we look is the too high fee, something we have done traditionally for many years. Beyond that, we must look at utilization—that is the number of services rendered —and even beyond that to the efficiency and quality of care rendered.

The traditional technic for peer review has been the Grievance Committees which look at physicians about whom there has been a complaint—usually already known to all the doctors in the area. But, what we are speaking of now goes well beyond this. In parts of the country it has been possible to do a form of total claims review by computer. Here can be developed the number of visits per day; the number of visits per patient; the number of visits per diagnosis; the number of injections given per visit; and the number of laboratory and x-ray tests per visit. From this, one may obtain an over-all view of a physician's practice. Dr. Donald Harrington, an AMA consultant, has set up data from electronic observation which have enabled him to spot "deviant practitioners"—those doctors who have an unusual number of injections per patient visit in the office, or others who never seem to be able to see a patient without doing a urinalysis or blood count, those who must see a patient two or three times a week for a rather routine diagnosis, such as osteoarthritis. However, Doctor Harrington would be the first to tell you that you cannot leap to conclusions simply from a computer analysis. There are all sorts of reasons for variations from the norm in practice. The mere fact that a man practices in a different way is no proof that he is a "bad" practitioner. In this country uniformity and conformity are not necessarily the ideal.

There are other reasons for errors in the computer method including local variations, particularly the differences in style of practice between rural and urban doctors, and of the disadvantaged areas versus the middle class suburbs.

The next step must always be to pull out the original claims forms for review. Here one can look over the number of tests paid for on the basis of the diagnosis and the amount of treatment and its relevance to the diagnosis. Once the committee has gone through the computer analyses, selected from it those claims forms it needs for review, and then reviewed these forms from unusual practitioners, it still has not established the fact that the doctor involved practiced a poor quality of care. A review of quality can be done only locally; it can be done only by people who understand the variations and circumstances, which in the end means that it can be done only by other local physicians. It must be done by physicians, because lawyers for instance are so bound by technicalities that common sense or what is best for the people rarely enters their minds and to allow them control of the program would be disastrous.

Consider the benefits of a peer review program. There are obviously direct benefits to the taxpayers, also to the reviewing physician, and to the physician who is reviewed. There are other benefits. One of these comes from publicity. It is no secret that the medical profession has a "bad image." The knowledge that the doctors in the County Medical Society are spending hours reviewing the quality of care can do only good things for us. In the past, we have allowed publication of only bad publicity about doctors. In the past, if the doctor did something good for a patient, we have forbidden this news to be printed because we felt it amounted to advertising. However, if something bad happened—a drunk driving conviction or malpractice suit—nothing the Medical Society could do would ever keep the news out of the paper. For this reason, our patients have read only unfavorable things about doctors and formed that kind of an opinion. I must suggest as an aside to the principal subject that we may have to reconsider our entire concept of physician publicity. However, whether we need to change our attitude toward publicity or not, there can be no doubt about our need for peer review.

The people of this country deserve to know their medical care is all it should be. The best guarantee of this can be given only by the concerned physicians of an area working together in an effective program of Peer Review.

Congress demands it; our patients deserve it: and we need it!

ANNOUNCEMENTS

Maxillofacial Anatomy And Surgery

A one week course on maxillofacial anatomy and surgery will be presented beginning March 30 at the University of Pennsylvania. The first three and one half days are devoted to lectures and laboratory sessions in the anatomy and functional relationships of the maxillofacial area conducted by the Graduate Department of Anatomy. This is succeeded by two and one half days of lectures, clinical presentations, and panel discussions of maxillofacial surgery. In addition to the faculty of the University of Pennsylvania, outside lecturers with special interest in this field will contribute to the program.

The course will be given in the Anatomy Laboratories of the School of Medicine and the Graduate Hospital of the University of Pennsylvania at the following times:

Anatomy March 30-April 2 ($100)
Surgery April 2-April 4 ($100)
(Both sessions, $175)

Inquiries for admission should be sent to the Office of Graduate Medical Education, 288 Medical Laboratories Building, University of Pennsylvania, Philadelphia, Pennsylvania.

Cancer Chemotherapy Course

The Medical Society of New Jersey is cosponsoring a course developed by the New Jersey Regional Medical Program, the Cooper Hospital, and the New Jersey College of Medicine and Dentistry. This is devoted to chemotherapy in cancer, including the use of alkylating agents, hormones, vinca alkaloids, methyl hydrazine, and other chemicals. Lectures and demonstrations are held every Thursday during March and April from 3 to 4:30 p.m. at the Cooper Hospital, 600 Stevens Street in Camden. For topical schedules write to the New Jersey Regional Medical Program at 88 Ross Street, East Orange 07018.

Emotional Problems In Office Practice

How do you handle common emotional problems of the patients who come into your office? A course has been developed to provide answers to this question. Sponsored by Columbia University, under the designation, *Psychiatry-PM-7*, it will be given on Wednesdays from 12 noon to 3 p.m. The first program will run from April 1 through June 3. This will be repeated October 7 through December, 1970. A third course is scheduled for 1971 starting on April 7. Classes will be held at the New York Psychiatric Institute at 726 West 168 Street, New York City. The course consists of ten 3-hour seminars centering around live and videotaped case presentations from family physicians' practices, illustrating treatment appropriate to office practice. Emphasis is given to the diagnosis of a patient's needs and the application of the appropriate method to achieve symptom relief, crisis resolution, long term support, and personality change. Recent advances in short-term therapy, such as behavior therapy and the technics of Masters and Johnson for sexual disorders will be given special consideration. For further information, write to Melvin D. Yahr, M.D., Associate Dean, Columbia University College of Physicians and Surgeons, 630 West 168 Street, New York 10032.

Clinical Application of Basic Sciences

The continuing series on the Basic Sciences and Clinical Application offered by the Burlington County Memorial Hospital has announced the following program for April:

April 2—Management of Painful Syndrome of the Head and Neck
April 9—Rheumatoid Arthritis
April 16—Fits, Faints, and Funny Turns
April 23—The Significance of Hypoglycemia
April 30—Congestive Heart Failure

The meetings (all Thursdays) will start promptly at 3:30 p.m., and are held in the

T. J. Summey Building of the hospital. AAGP gives one and a half credits per session. For further information please write to the Director of Medical Education at the hospital (J. R. Wolgamot, M.D.), 175 Madison Avenue, Mount Holly, New Jersey 08060.

Blood Components Workshop

A two-day workshop on Blood Components has been scheduled for April 2 and 3 at the Military Park Hospital in Newark. This is sponsored by the New Jersey Blood Bank Association, in conjunction with the American Association of Blood Banks. For registration and further information communicate with Dr. Herbert L. Goodman at the East Orange General Hospital. Medical technologists, as well as physicians are welcome.

Symposium on Peripheral Vascular Disorders

A two-day colloquium on peripheral vascular disorders has been scheduled for April 3 and 4 at the Waldorf-Astoria in New York. An eminent faculty has been recruited and many practical aspects of both the medical and surgical problems of peripheral vascular diseases will be presented. For more details write to the Peripheral Vascular Society of America, 1104 Lexington Avenue, New York 10021.

Comprehensive Child Care

Mark it in your book now—April 22 at the Holiday Inn in New Brunswick. That is the date and place for the unusual colloquium on comprehensive child care sponsored by The Medical Society of New Jersey, the New Jersey Public Health Association, and the New Jersey component of the American Academy of Pediatrics. The morning session starts at 9:45, and the afternoon program runs from 2 to 4 p.m. The agenda covers material on genes, family life, birth, preservation of sound health, community problems, and schooling. Advance luncheon reservation is necessary ($5). Please contact the New Jersey Public Health Association, 118 West State Street, Trenton 08608.

Camp for Diabetics

New Jersey's only camp for diabetic children in Stillwater, New Jersey, is going to start its thirteenth season on June 28. Known as Camp Nejeda, it is sponsored by the New Jersey Diabetes Association, which is an organization of physicians. If any of your patients are (or have) diabetic children consider their possible attendance for two or three weeks during the summer of 1970. This is a coeducational, non-sectarian camp, and diabetic children are accepted regardless of their ability to pay the full tuition of $80 per week. For more details, write to Camp Nejeda, 317 Belleville Avenue, Bloomfield, New Jersey 07003.

EENT—Plastic Surgery Program In Europe

During the first two weeks of May the Second Congress on Ophthalmic and Otolaryngic Plastic Surgery will hold meetings in Moscow, Leningrad, Vienna, and Rome. An excellent and unusual program has been developed, allowing ample time for sightseeing. The plane leaves New York on Friday, May 1 and will return on Sunday, May 17. For further information, write to the coordinator for New Jersey, Dr. Ralph L. Dicker, 395 West Blackwell Street, Dover, New Jersey 07801.

Physicians Trip To Israel

The American Physicians Fellowship offers a tour of Asia Minor in conjunction with the Eighth World Assembly of the Israel Medical Association, to be held in Jerusalem, Haifa, and Tel-Aviv, May 18 to May 29. The tour, the 13th of its kind, leaves New York on May 16 and returns on May 31. The cost is $950. Further information is obtained from Dr. Manuel M. Glazier, American Physicians Fellowship, 1622 Beacon Street. Brookline, Mass.

Medical Trip to Japan and Hong Kong

For only $898 per person you can fly to Tokyo and Hong Kong and back during July 1970. This is a trip sponsored by the Bergen County Medical Society, and all members of

MSNJ are eligible to participate. Included is first class service on the plane and hotel accommodations in both Tokyo and Hong Kong, with breakfast and dinner every day. There will be medical symposia each morning, with the afternoon free.

You can even pick up an outside trip to Osaka to visit Expo-70, the first world exposition held in the Orient. If you are interested get in touch with the Bergen County Medical Society, 215 Union Street, Hackensack.

Electroencephalographic Meeting

Washington, D.C. is the place and September 17, 18, and 19 the time for the next session of the American EEG Society. If you have a paper you would like to submit, send an abstract of it, before May 13, 1970, to Dr. Reginald Bickford at the Department of Neuroscience, University of California, La Jolla, California 92037. For a copy of the program, also write to Dr. Bickford.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

March

5 to Apr. 30 — **New Jersey Regional Medical Program, New Jersey College of Medicine and Dentistry, Academy of Medicine of New Jersey, and The Cooper Hospital**
Cooper Hospital, Camden
"Cancer Chemotherapy"

10 — **Academy of Medicine of New Jersey**
Section on Dermatology and
New Jersey Dermatological Society
Paterson General Hospital
Paterson

10 — **Bergen County Medical Society**

11 — **Holy Name Hospital**
Teaneck
"Dietary Management of Kidney Disease"

11 — **Middlesex County Medical Society**

11 — **Ocean County Medical Society**

11 — **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

11 — **St. Michael's Medical Center**
Newark
Endocrine Review

11 — **Essex County Heart Association**
Mountainside Hospital
Montclair
Symposium

12 — **Academy of Medicine of New Jersey**
John E. Runnells Hospital
Berkeley Heights
Symposium: Coronary Care Units

12 — **Burlington County Memorial Hospital**
Mount Holly
Recent Advances in the Treatment of Leukemia

18 — **Academy of Medicine of New Jersey**
Overlook Hospital
Summit
Colloquium on Suicide

19 — **Burlington County Memorial Hospital**
Mount Holly
Chemotherapy of Disseminated Solid Tumors

19 — **Academy of Medicine of New Jersey**
Somerset Hospital
Somerville
Symposium: Hypnosis in Medicine

19 — **Gloucester County Medical Society**

19 — **Morris County Medical Society**

20 **Academy of Medicine of New Jersey**
Cooper Hospital
Camden
Symposium: Pulmonary Problems

20 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

21 **Academy of Medicine of New Jersey**
Section on Anesthesiology
Orange Memorial Hospital
Orange
"Therapeutic Block for Pain of Carcinoma"

23 **Academy of Medicine of New Jersey**
North Hudson Hospital
Weehawken
Symposium on Emergency Room Care

24 **Hunterdon County Medical Society**

26 **Academy of Medicine of New Jersey**
Section on Radiology
Bloomfield
Interesting X-rays of the Month

26 **Burlington County Memorial Hospital**
Mount Holly
Differential Diagnosis of the Polycythemic States

30 **Cape May County Medical Society**

April

2 **Burlington County Memorial Hospital**
Mount Holly
Management of Painful Syndromes of the Head and Neck

2 **St. Joseph's Hospital**
Paterson
Program on Stroke

2-30 **New Jersey Regional Medical Program, New Jersey College of Medicine and Dentistry, Academy of Medicine of New Jersey, and The Cooper Hospital**
Cooper Hospital
Camden
"Cancer Chemotherapy"

2-3 **St. Barnabas Medical Center and Academy of Medicine of New Jersey**
St. Barnabas Medical Center
Livingston
Culdoscopy and Peritoneoscopy

7 **Hudson County Medical Society**

8 **St. Barnabas Medical Center**
Department of Obstetrics and Gynecology
Livingston
"New Aspects of Irradiation Therapy"

8 **Academy of Medicine of New Jersey**
Hoffmann-LaRoche
Nutley
Symposium: "Surgical Management of Behavior"

8 **Middlesex County Medical Society**

8 **Ocean County Medical Society**

8 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

9 **Burlington County Memorial Hospital**
Mount Holly
Rheumatoid Arthritis: Current Concepts of Differential Diagnosis and Management

10 **Academy of Medicine of New Jersey**
Cooper Hospital
Camden
Symposium: Hypnosis in Medicine

10 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Symposium: Pulmonary Problems

14 **Bergen County Medical Society**

14 **Cumberland County Medical Society**

14 **Academy of Medicine of New Jersey**
Section on Dermatology
Chanticler Restaurant
Millburn
Cryotherapy in Dermatology, 1970

15 **Academy of Medicine of New Jersey**
Section on Urology
Marriott Motor Inn
Saddle Brook
Awards Dinner

15 **Academy of Medicine of New Jersey**
Section on Dentistry
Veterans Administration Hospital
East Orange
Symposium: "Preventive Dentistry"

16 **Burlington County Memorial Hospital**
Mount Holly
Fits, Faints, and Funny Turns

16 **Gloucester County Medical Society**

16 **Morris County Medical Society**

17 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

21 **Warren County Medical Society**

23 **Burlington County Memorial Hospital**
Mount Holly
The Significance of Hypoglycemia

23 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Bloomfield
Interesting X-rays of the Month

30 **Burlington County Memorial Hospital**
Mount Holly
Definition, Etiology, and Classification of Congestive Heart Failure; The Pathology and Dynamics of the Failing Heart

May

1 **Academy of Medicine of New Jersey**
Eye Division
Dyslexia

4 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

5 **Hudson County Medical Society**

6 **New Jersey Heart Association**
Rutgers
New Brunswick
Myocardial Infarction and Drug Therapy

6 **St. Michael's Medical Center**
Newark
Controversies in Management of Heart Problems

6 **St. Barnabas Medical Center**
Livingston
Familia Toxemia

7 **Burlington County Memorial Hospital**
Mount Holly
Evaluation and Medical Management of Acute and Chronic Heart Failure

12 **Bergen County Medical Society**

13 **Ocean County Medical Society**

13 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

14 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Heart Disease and Selection of Patients for Heart Transplant

16-19 **The Medical Society of New Jersey**
Chalfonte-Haddon Hall
Atlantic City
Annual Meeting

21 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Management of Pulmonary Embolic Disease

21 **Gloucester County Medical Society**

21 **Morris County Medical Society**

25 **Cape May County Medical Society**

27 **Academy of Medicine of New Jersey**
Mayfair Farms
West Orange
Annual Awards Dinner

27 **Middlesex County Medical Society**

June

3 **New Jersey Gastroenterological Society**
Newark
Annual Meeting

9 **Bergen County Medical Society**

9 **Cumberland County Medical Society**

10 **Middlesex County Medical Society**

10 **Ocean County Medical Society**

10 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

16 **Warren County Medical Society**

18 **Morris County Medical Society**

19 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

July

17 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

August

21 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

LETTERS TO THE JOURNAL

Benefit Of Clergy

Dear Sir:

A few days ago, I had an experience which was new to me and which I wanted to share with the other members of the New Jersey Society. A college student, age 19, coming from a nice, middle-income family, telephoned and said that she was pregnant, that she was on her way to Puerto Rico to have an abortion performed. She visited me together with her mother, and I got the following story which was substantiated by showing me an article which appeared in *The Lutheran*, Vol. XIII, January 7, 1970. This was written by the pastor of a church in New Jersey.

The pastor is a member of the "Clergy Consultation Service on Abortion" which advises women, who got themselves pregnant but who do not want to go through with it, to go to Puerto Rico and have an abortion performed. The pastor writes that he was confronted by a lady who felt that she could not endure nine months of pregnancy since her boyfriend refused to marry her. After having contacted the "Clergy Consultation Service on Abortion" in New York, he relates as follows: "The next evening I was able to get her the name of a gynecologist in Puerto Rico. Two days later she had an abortion and was back in college a day after that." He then goes on to cite the example of a 14 year-old girl who was impregnated by one of her co-ed students. "Yet, the abortion committee of doctors in the local hospital refused to authorize a therapeutic abortion for this girl. The gynecologist who finally referred her and her parents to me said, 'Thank God that there is someone in this community who will treat this girl and her parents with compassion and understanding. Your congregation is to be commended for allowing you, as its pastor, to offer this counseling service.' . . . Consequently, the girl and her mother went to England where a gynecologist and a psychiatrist readily agreed that an abortion was the human thing to do."

This vitally interested me as a board-certified gynecologist. I have been under the impression that, under New Jersey law, not only he who performs an abortion is liable to punishment, but also the procurer who sends the girl to the abortionist. How is it possible that reputable physicians are unable to do anything for these unfortunate women who, in my opinion, should have the innate right to determine whether they want to go through with a pregnancy or not? The abortion committees of most hospitals are reluctant to permit any therapeutic abortion to be performed, and, unless there is some cogent reason, deny the application. One hospital with which I am connected and which shall remain nameless even requires any application for therapeutic abortion to be made out in duplicate and the copy has to be sent to the prosecutor.

It seems to be time that the medical profession, following in the footsteps of the ministry, should do something in a matter which is purely medical and has very little to do with theology. One would seriously question the wisdom of the management of a girl who has been aborted in Puerto Rico and "who is back in college the next day." Besides that, I am asking why two standards of legal practice are applied to ministers and physicians. How can ministers refer patients to abortionists in Puerto Rico or elsewhere without any legal complications?

(signed) Werner Steinberg, M.D.

Editor's Note: The following extract from the minutes of November 16, 1969 Trustees' meeting would seem to be relevant here:

"Attention was called to an article that appeared in *The Bergen Record* on 30 October 1969, and to a recent TV program on Channel 7 concerning a minister in East Rutherford and some 30 consultants who have been reported to have arranged more than 1,000 abortions in the past 11 months.

It was the conclusion of the Board that involved in this program are acts that seem to be in basic conflict with New Jersey law and its intent to safeguard the right to life of the unborn child. Accordingly, the Board decided to refer the matter to the Attorney General for investigation and adjudication."

Truth, The Best Policy

Dear Sir:

Having handled malignant disease for the last 37 years, the editorial that appeared in the recent issue of *THE JOURNAL* of The Medical Society of New Jersey, entitled "Lies Can Save Lives," seems to be naive. This is the way we used to practice and would still like to practice this way. Recent court decisions have outdated this philosophy. On serious situations of major proportion, we have been forced by the courts to be very explicit in our informed consent procedures. It is now necessary completely to explain an operation and the possible complications that might develop from this procedure, and having noted this on the chart have the patient initial it.

It would seem to me that your next editorial should be aimed at the legal profession and the judiciary in the hopes that you might obtain some type of practical solution to this problem. I admit that in some instances this has caused considerable mental trauma. We do not like to practice that way. We are forced to.

Read *Medicolegal Forms With Legal Analysis* from the AMA Law Department. Then you can shudder every time you treat a patient.

(signed) William O. Wuester, M.D.

Editor's Note: Actually we suggested telling a responsible family member, not the patient, if the news of a hopeless diagnosis was too traumatic emotionally, but did not recommend that treatment procedures be modified to conform to this.

204th Annual Meeting

May 16-19, 1970

Chalfonte-Haddon Hall

Atlantic City

OBITUARIES

Dr. D'Arcy C. Clarie

Word has just been received of the death on October 3, last year, of D'Arcy C. Clarie, M.D., one of our state's leading anesthesiologists. He had been President of the New Jersey Society of Anesthesiologists, and was board certified in his specialty. Dr. Clarie was a major in the medical corps of the Army of the United States during World War II. Thereafter, he became chief of anesthesiology at the Holy Name Hospital in Teaneck. Dr. Clarie was born in 1908, and earned his M.D. at the Downstate Medical School of New York (the former Long Island College Hospital) in 1933. He was a Fellow of the American College of Anesthesiologists and a member of our Bergen County Medical Society.

Dr. Harrison F. English

The Delaware Valley lost one of its best known psychiatrists with the death of Harrison F. English, M.D. on January 15, 1970. Dr. English was only 57 at the time of his death. He was a 1938 graduate of the Jefferson Medical College. After finishing internship and taking graduate work in psychiatry, he accepted a commission in the Army of the United States, serving almost three years, most of it in Europe, and was demobilized with the rank of Lieutenant Colonel. He was the first Medical Director of the New Jersey Mental Health Center, and a psychiatric consultant to various state agencies. Dr. English was a Fellow of the American Psychiatric Association and a Diplomate of the American Board of Psychiatry and Neurology. He had served as President of the Trenton Civitan Club and was a trustee of the public library in our State's capital city.

Dr. Katharine A. Gurley

Dr. Katharine A. Gurley, a Jersey City pediatrician and general practitioner, died on January 11, 1970 at the age of 59. She was

active in committee work for the Hudson County Medical Society and had earned her M.D. at Columbia University's College of Physicians and Surgeons in 1936. Dr. Gurley was on the pediatric service at St. Francis Hospital in Jersey City.

Dr. George R. Hatcher

At the untimely age of 47, the promising career of George Ralph Hatcher, M.D., was cut off on January 30, 1970. He had earned his M.D. at Western Reserve in 1948 and served for some years as a flight surgeon in the U.S. Air Force. He then accepted a residency at the Rockland State Hospital in Orangeburg, New York, and came to New Jersey to serve on the staff of the Veterans Administration Hospital at Lyons. He was on active duty with the Navy for a year as chief of psychiatry and neurology at the Navy Hospital in Bainbridge, Maryland. In 1954 Dr. Hatcher moved to Millington, New Jersey, entering private practice, and became attending psychiatrist and neurologist at the Morristown Memorial Hospital.

Dr. William H. Huber

A prominent Essex County surgeon, William H. Huber, M.D., of Montclair, died on December 26, 1969, at the age of 76. Dr. Huber was a 1921 graduate of the Medical School of St. Louis University. He was active in affairs of the New Jersey Society of Surgeons, was a Fellow of the American College of Surgeons, and during most of his professional career had been affiliated with the St. James' and St. Michael's Hospitals in Newark.

Dr. Ralph W. Maio

Ralph W. Maio, M.D., died on January 16 at the age of 58. Dr. Maio was a graduate of the Hahnemann Medical College, class of 1938, and was one of New Jersey's leading anesthetists. He was board certified in his specialty, a Fellow of the American College of Anesthesiology, a member of the New Jersey State Society of Anesthesiologists, and head of the Department of Anesthesiology at the Bayonne Hospital.

Dr. Royce Paddock, M.D.

Born in 1889, during the Presidency of Benjamin Harrison, Royce Paddock, M.D., led a long and useful life. He was an internist, a member of Columbia University's distinguished class of 1941. Dr. Paddock did pioneer work in allergy in the 1920s, when that specialty was just beginning. He served the St. Barnabas Hospital for many years as attending allergist. He died on November 5, 1969.

Dr. Irving M. Rollins

The Medical Society of New Jersey has just been informed that one of its former members, Irving M. Rollins, M.D., had died on October 26, 1969. He had been a member of the Essex County Medical Society, and during the riots in Newark in 1968, he won nationwide recognition for having worked around the clock for almost 72 hours. Born in 1918, he won his M.D. at New York Medical College in 1942. He served with the U.S. Air Force from 1943 to 1946 and then accepted a surgical residency in Brooklyn. He soon earned a board diploma in surgery and became a Fellow of the American College of Surgeons. He was active in the affairs of the International College of Surgeons as Chairman of its Examination Committee. Dr. Rollins was on the faculty of both the New Jersey College of Medicine and his alma mater. After leaving New Jersey he moved to Alexandria, Virginia, to accept appointment as the Medical Director of the Tobacco Institute in Washington, D. C. While in New Jersey, Dr. Rollins was active in our State Society's Committee on Medical Education.

Dr. Michael Sokol

A coronary attack on January 17, 1970, took the life of Michael Sokol, M.D. Born in Poland in 1917, he was graduated in 1949 from the Medical School at Marburg, Germany. In 1950, he came to the USA and worked at the Bergen Pines Hospital in Paramus. He then took a residency at the New Jersey Neuropsychiatric Institute, and later accepted a staff appointment at the New Jersey State Hospital in Trenton.

BOOK REVIEWS

Atlas of Human Electron Microscopy. Ruben P. Laguens and Cesar L. A. Gomez Dumm. St. Louis, 1969, Mosby. Pp. 180. Illustrations 150. $20.50

This book, moderate in size and of modest cost (considering the number and quality of illustrations) is "intended especially for medical students, pathologists who are beginning the study of electron microscopy, and physicians in general." There are several good atlases on this subject but I find this one to be more all-inclusive. It is unique in that all tissues illustrated are of human origin.

The text includes all organs and tissues of the human body except bone, cartilage, skeletal muscle, eye, and inner ear. It is stated, and I concur, that the first three are omitted because the cells are no different in man than in other species and they have already been adequately presented in other books. I suppose the last two are omitted because these are very specialized organs and their detailed structure is not generally in the area of interest of those for whom this Atlas is intended. There is no text as such, but the legends with each illustration are concise and offer much information. The illustrations (all electron micrographs) are generally good and some are superb. The magnifications range from 3,600 to 160,000—most are between 5,000 and 15,000—and this is proper as it is the range of magnification generally used by the pathologist who is using an electron microscope in his daily work.

This is a good book and admirably fulfills its function of offering a basic knowledge of normal human histology and cytology as seen with the electron microscope. This is an additional dimension in pathology and of course one must be acquainted with the normal before one can even recognize, let alone understand, the abnormal.

HUGH F. LUDDECKE, M.D.

Personnel Administration and Labor Relations in Health Care Facilities. J. O. Hepner, Ph.D.; J. M. Boyer, M.A.; and Carl Westerhas, M.S. St. Louis, 1969, Mosby. Pp. 391. ($15)

More than three million persons are employed in "the health industry" as the authors call it. This presents a labor relations' problem of no small magnitude. Hospitals and nursing homes have been somewhat slow to develop personnel programs, collective bargaining methods, fringe benefits and competitive wage scales. Perhaps this is because so many women work in this field, or because the jobs at the bottom level look like dead-end ones, or because the whole idea of striking against the sick seems unconscionable—for whatever reason, personnel management is a poorly developed aspect of hospital, clinic, and nursing home administration. Yet payroll accounts for 65 to 80 per cent of the expenses in hospitals and nursing homes.

The time has come for larger health care institutions to set up personnel departments headed by well trained directors. This book is addressed to trustees, administrators, and physicians, and also offers the personnel expert a practical volume on the peculiar personnel problems of health care facilities. The authors cover collective bargaining, personnel procedures, training of manpower, development and interpretation of legislation, the role of the physician in the hospital-nursing home hierarchy, and providing the atmosphere in which hospital personnel administration can function. The word "strike" does not appear in the index.

This manual contains facts and principles of interest to every hospital administrator, and it wouldn't hurt the senior doctors to read it either. For the personnel administrator this text can constitute a real blue-print.

VICTOR HUBERMAN, M.D.

Preventive Medicine in The United States Army 1607-1939. Stanhope Bayne-Jones, M.D. Published by the Department of the Army, 1969. Washington, D. C. Pp. 255 with 39 illustrations. ($2.50, U. S. Government Printing Office)

Health is something you have to struggle for. When you work with large numbers of men and women under overcrowded and unsanitary conditions, the struggle must be unremitting and most people are not well enough disciplined to maintain the necessary level of sanitary precautions. If the Army provides the liabilities of overcrowding and difficult sanitary conditions, it also provides the coercive and, if need be, compulsory methods of enforcing sanitary standards. In this slim book we have a well written account of what the Army of the United States has done between the American Revolution and start of World War II in its preventive medicine program.

It was the Army's medical corps that fathered both the U.S. Weather Bureau and the Army Signal Corps. From this small corps came the conquest of yellow fever, the control of malaria, and the sanitary achievements that made the Panama Canal possible. Among the ranks of army physicians one must mention William Gorgas, William Lyster (remember the Lyster bag?). Edward Munson (the "Munson last" for foot comfort), William Henry Welch, and, of course, the incomparable Walter Reed. The preventive medicine accomplishments of the Army Medical Corps are achievements that even the anti-establishmentarians will view with pride.

WILLIAM S. SCHRAM, M.D.

At Your Own Risk—The Case Against Chiropractic. Ralph Lee Smith. New York, 1969, Pocket Books (Simon and Schuster). Pp. 178. (Paperback—95c)

The practicing physician never knows quite how to handle a patient's queries about chiropractic. Chiropractors have warned their public that the M.D.s, out of professional jealousy, will be criticizing them. But they add that their almost universal acceptance by state governments in the USA proves that they must have something to offer. And they publish documents to support their claim that chiropractic makes sick people well. Some physicians think that the way to handle this is by ignoring it. Others want us to fight back. Some say that if we offer to document the case against chiropractic, we will be dignifying them by a serious answer. Others say that we should use the same polemical approach.

Well, here is one answer. Mr. Smith has brought together a good deal of material on chiropractic, and, without any excessive voice raising, has shown why it is based on unsound principles. He has described his personal experiences as a patient of chiropractors. He reviews their professional education. He recites a few cases of medical neglect occasioned by the family's taking time out to try chiropractic—and some of these stories will make your hair stand on end. He even suggests a way to withdraw chiropractic licenses, but to turn the better equipped and more intelligent chiropractors into useful members of the medical and paramedical community (by retraining them in physical therapy, x-ray technology, and so on). He includes some interesting comment on how chiropractors have achieved their legislative victories. All in all this is a handy little book to have around, and to recommend to patients. And all this for only 95 cents!

HENRY A. DAVIDSON, M.D.

Modern Treatment (Vol. 6, #4): **Psychiatry in Medical Practice.** Ephraim T. Lisansky, M.D. and Bernard T. Schochet, M.D., Editors. New York, 1969, Hoeber Medical Division, Harper and Row, Pp. 276. ($16 per year by subscription)

During the past decade, the University of Maryland has sponsored a series of talks on psychiatry for the internist. These, together with some additional material, have been developed into this book. Fifteen authors contribute to the text, so that, as might be expected, there is considerable variation in the clarity and practicality of the material. Included are chapters on the role of the social worker, psychologist, and clergyman. The reader is told something about family therapy, handling a depression, the management of the dying patient, the use and abuse of psychotropic drugs, office psychotherapy by the nonpsychiatric physician, management of sociopathy and the addictions (nothing very usable here), handling the psychiatric aspects of acute illness, what to do about the ambulatory schizophrenic, and how to be supervised by a psychiatrist.

The subject matter does not lend itself to the "how to do it" blueprint which doctors so often want. But it does provide an indepth consideration of the many dimensions of the emotional climate of the patient.

Abraham Leff, M.D.

Handbook of Ocular Therapeutics and Pharmacology, Edition Three. Philip P. Ellis, M.D. and Donn L. Smith, M.D. St. Louis, 1969, Mosby. Pp. 251. ($10.75)

The practicing ophthalmologist will probably consult this volume more than any other on his shelves. The expressed purpose of the book is to present in a concise form the basic considerations of current ocular therapy and pharmacology. This it does beautifully.

The book is divided into two parts. The first, on therapeutics, presents some basic essentials of treatment and summarizes the present medical therapy of most ocular disorders. The second part, on pharmacology, describes the most commonly used medications that a practicing ophthalmologist might prescribe. The actions, uses, side reactions and contraindications, preparations, and dosages of these drugs are given.

Because of the conciseness of the book, some of the discussions of therapy are a bit dogmatic, but this is easily overlooked in so useful a book.

BERNARD SUSSKIND, M.D.

Tobacco and Your Health. Harold S. Diehl, M.D. New York, 1969, McGraw-Hill. Pp. 271. (Paperback—$2.95)

By now, you would think everyone would know that cigarette smoking is a serious health hazard; and those who shut their eyes to this, are not going to read still another book on it. Yet as Dr. Charles Ross puts it, "Cigarette smoking is the most serious public health problem this country has ever faced." It may be that water and air pollution are more serious problems, since these menace the non-smoker too. But smoking, after all, is a kind of private air pollution.

In this well illustrated volume, Dr. Diehl reviews the evidence that indicts cigarette smoking as a factor in emphysema, peripheral vascular disease, peptic ulcer, cirrhosis, accidents, dental disorders and, of course, carcinoma of the respiratory and upper gastro-intestinal tracts. The book is aimed at the sophisticated layman. The medical terms are carefully explained and a useful glossary is included for ready reference. Included is practical material on how to give up smoking. Dr. Diehl makes some comments on the propaganda of the cigarette industry, which appears to be recruiting more and more younger victims to make up its loss of customers through disenchantment or death. The American Cancer Society's pamphlet *If you Want to Give up Cigarettes* is included in its entirety in an appendix. Some of the statistical material, tabulation and graphs will bore readers, and at times the author seems to be driving home the point by saying the same things in different words or with different figures. However, in view of the difficulties some people have in being convinced, perhaps this repetition is necessary. The physician who has a patient on the brink, would do well to recommend this book to him. Provided, of course, that the doctor is not himself puffing a cigarette as he makes the recommendation.

JOSEPH LEO BARONE, M.D.

Atlas of Obstetric Technic. (2nd Edition). J. Robert Willson, M.D. St. Louis, 1969, Mosby. Pp. 313. Illustrations 375. ($19.75)

We are indebted to Professor Willson for creating or recreating a volume that combines the features of a textbook and a pictorial guide for the benefit of those who bear the direct responsibility for most of the deliveries in the world today. In fact, the medical student, the intern, the resident physician, the delivery room nurse, the nurse-mid-wife, and the family physician, occasionally (with the advice and consent of the obstetrician) may be delivering the majority of babies even in the English-speaking world. The text covers anesthesia and the mechanics of normal labor and delivery as well as the mechanics of abnormal labor and delivery and the frequently occurring complications. The book is clearly and amply illustrated and the writing is concise so that reference can be swiftly made to any particular subject and the necessary information quickly obtained. The author offers a great deal to the obstetrical specialist who deals with normal, uncomplicated labor and delivery 90 per cent of the time. While awaiting and anticipating a complicated, difficult labor and delivery, the obstetrican would benefit by refreshing his memory and reviewing the technics as disclosed in this book; for example, face presentation, cesarean hysterectomy, and so on. This valuable book should be made available to every delivery room.

JEROME ABRAMS, M.D.



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Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

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It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

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Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Actions—Ovulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen depresses the output of both the follicle-stimulating hormone (FSH) and the lutenizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates in the United States found relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives. This has not been confirmed in the United States.



Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for 2 months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: Increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

1. Royal College of General Practitioners: Oral Contraception and Thromboembolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967.
2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968.
3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969.
4. American Journal of Epidemiology (to be published).

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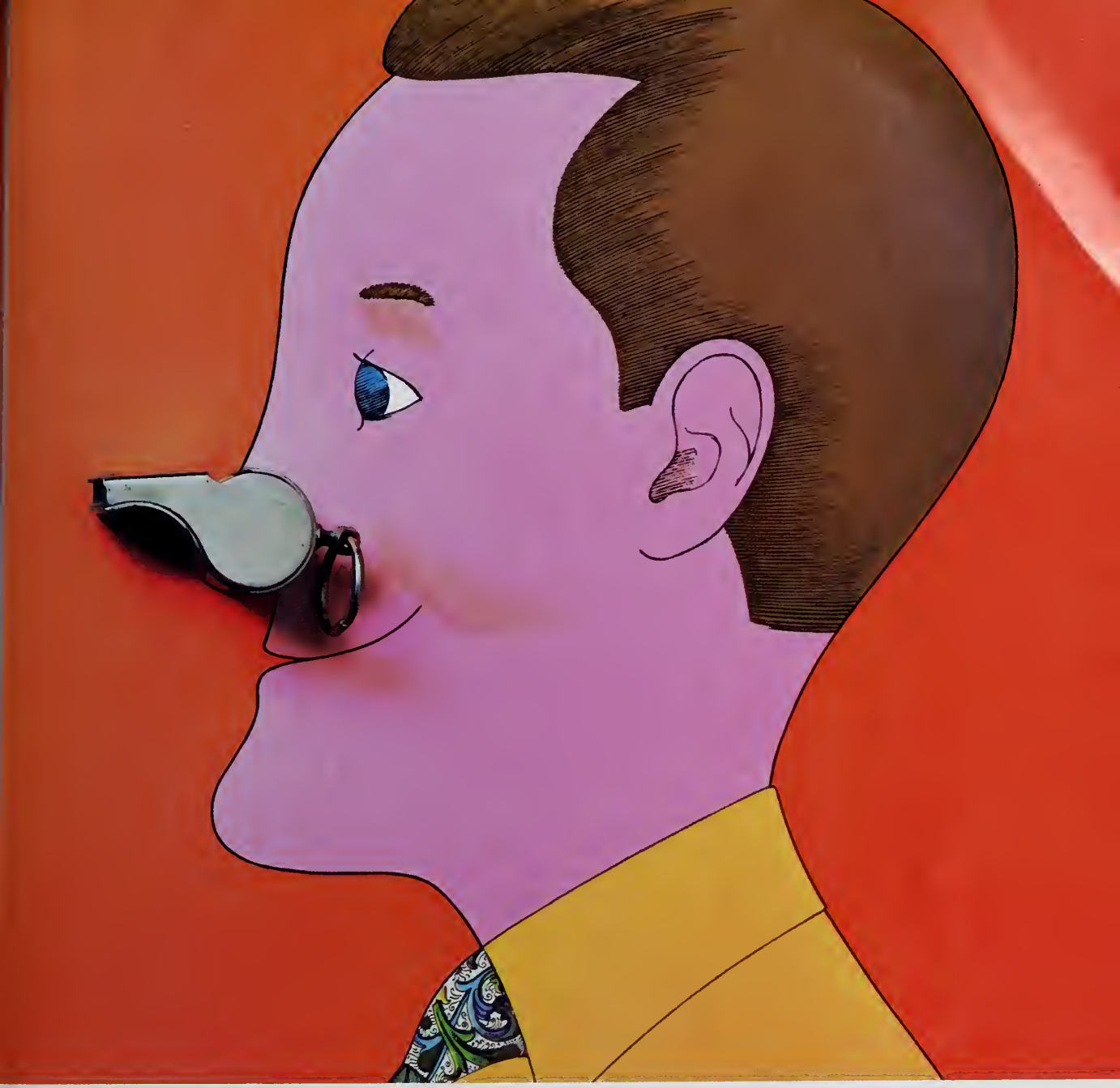
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Driver Escapes Serious Injury When Truck Jackknifes

SHENANDOAH, JULY 16. Roger Sherman of Waynesboro suffered head lacerations but escaped serious injury when the tractor-trailer he was driving skidded on Deep Run Bridge and jackknifed. It took rescue workers thirty minutes to remove him from the cab which was dangling over the edge of the bridge. Sherman is resting comfortably in University Hospital where his condition is listed as satisfactory.

Frankhouser called my attenti

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Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg. Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg. Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

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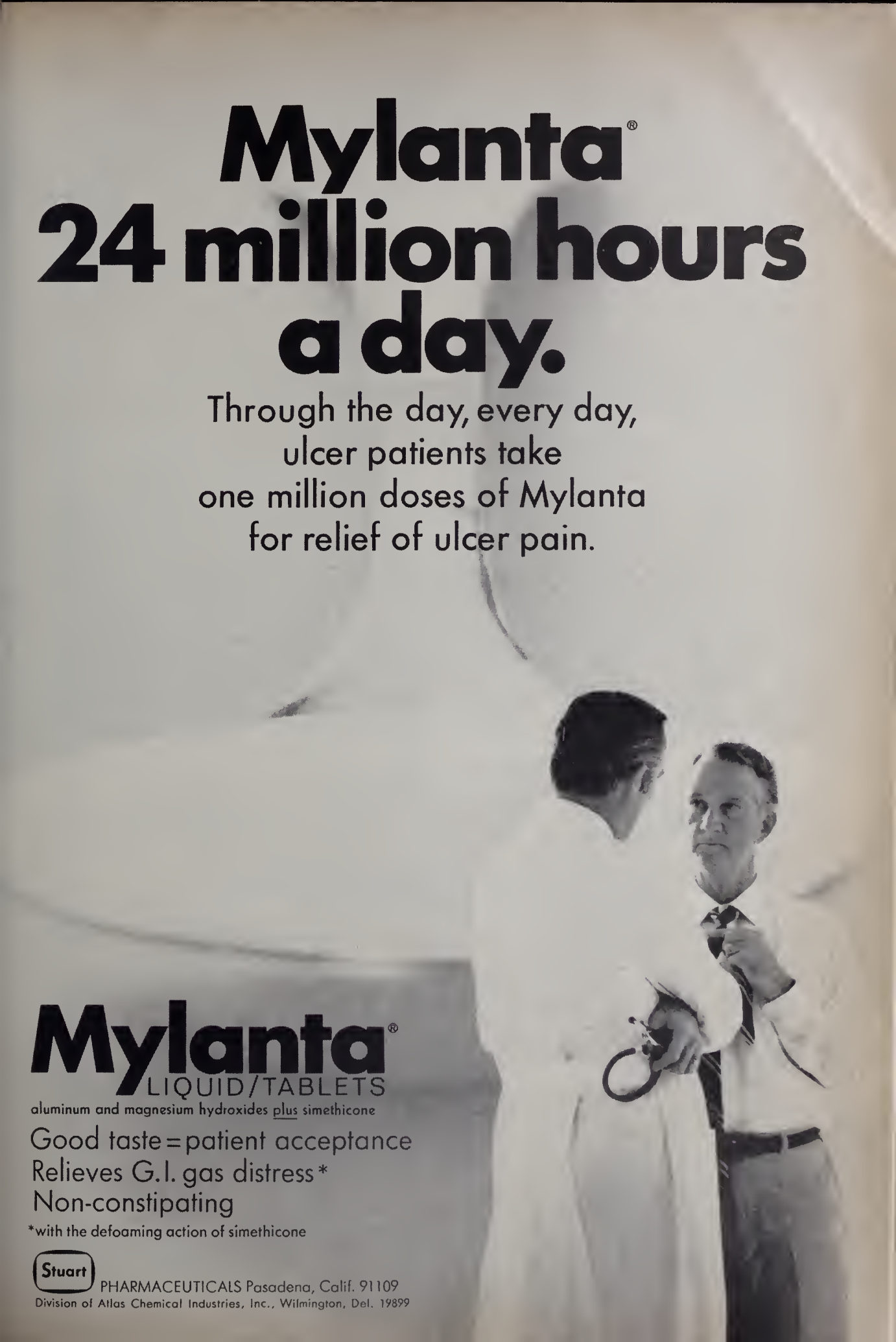
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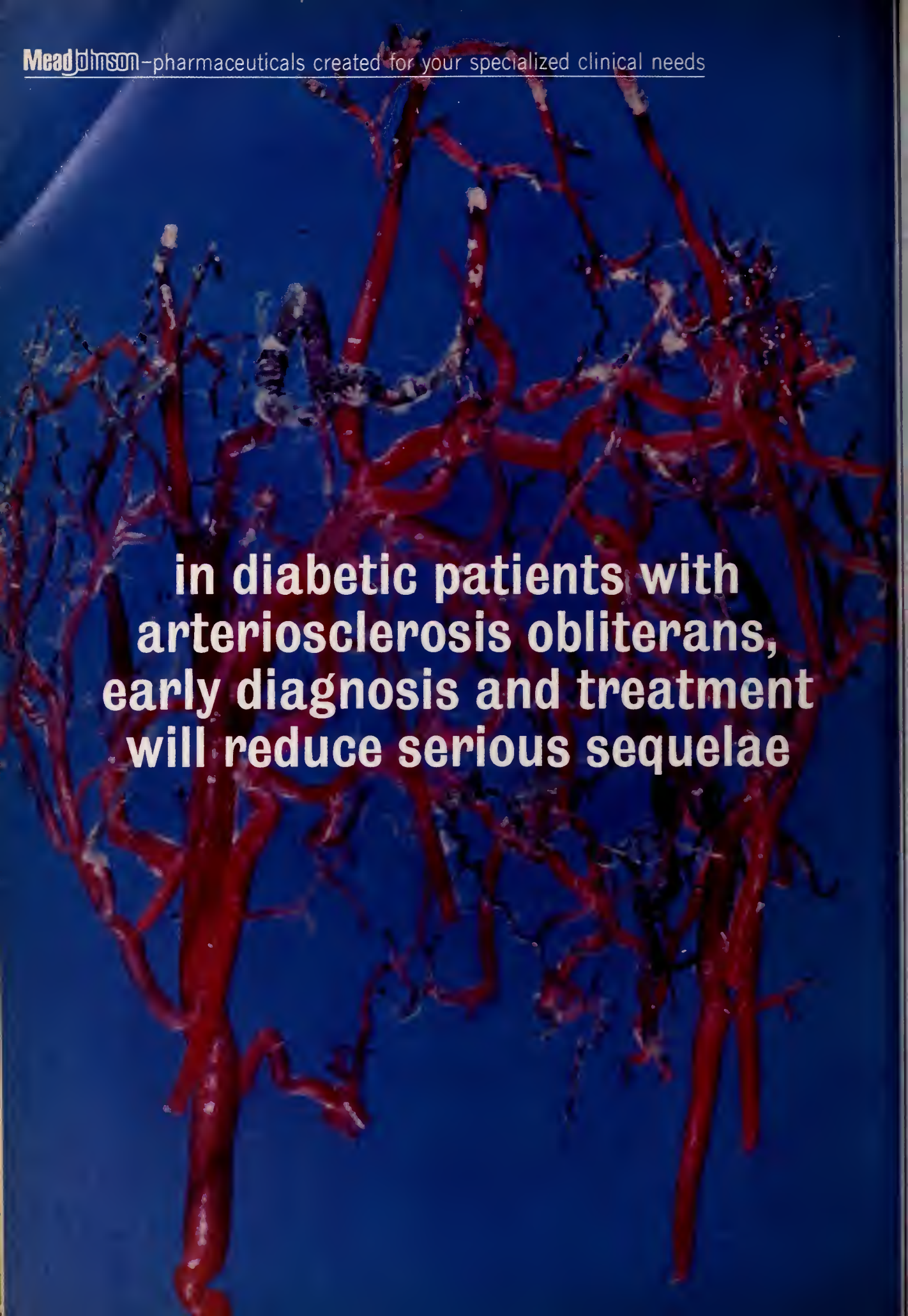
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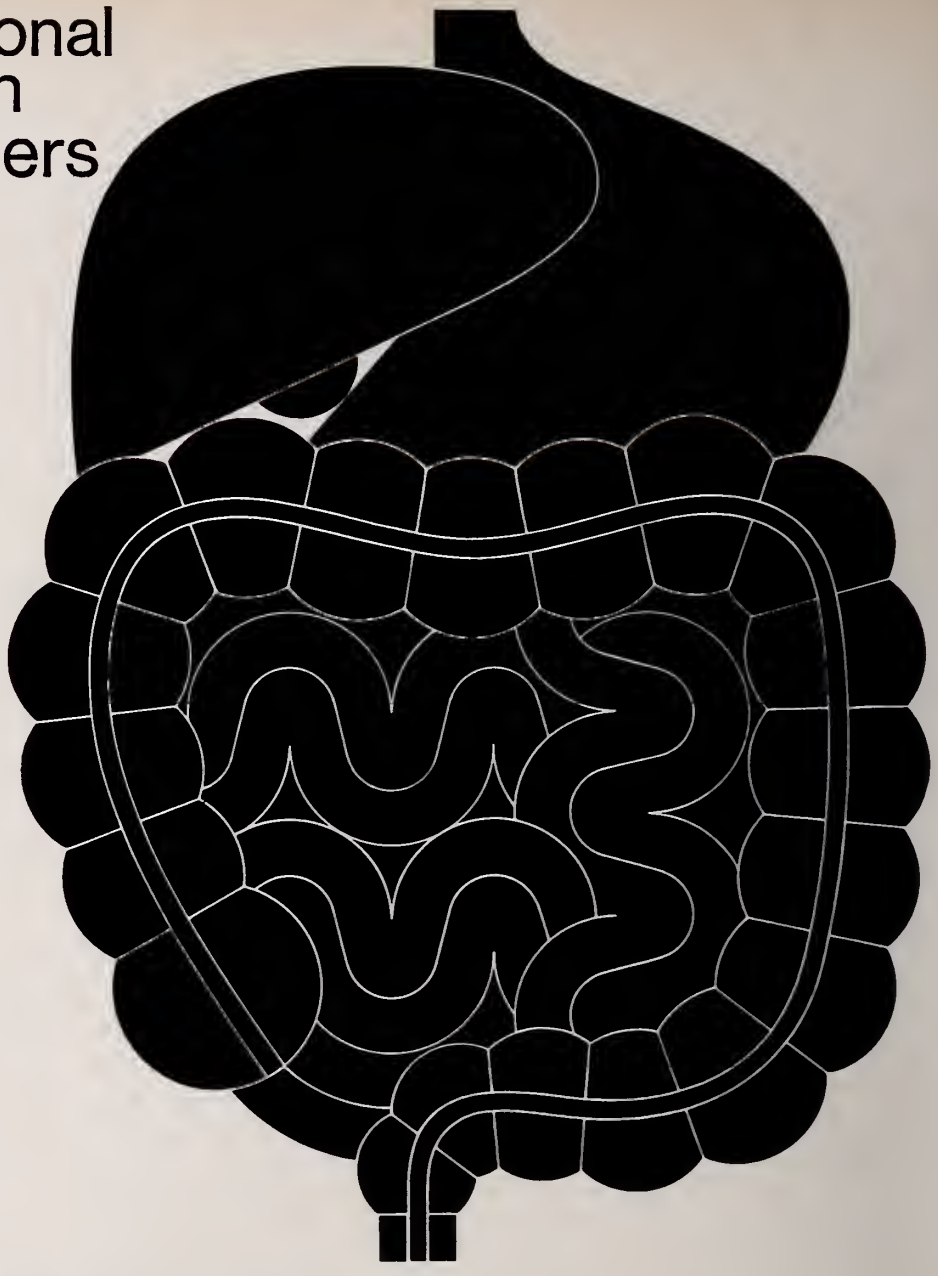
References: (1) Stein, I.D.: Angiology *15*:1 (April) 1964. (2) New Drugs–Evaluated by the A.M.A. Council on Drugs, Chicago, American Medical Association, 1967, pp. 295-297. (3) Samuels, S. S., and Shaftel, H. E.: J. Indiana M. A. *54*:1021-1023 (July) 1961. (4) Kaindl, F.; Pärtan, J., and Polsterer, P.: Wien.klin.Wchnschr. *68*:186-191 (March 16) 1956. (5) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: Angiology *10*:185-192 (Aug.) 1959. (6) Myers, K. A.: Modern Treatment *4*:370-383 (March) 1967. (7) Gillespie, J. A.: Angiology *17*:280-288 (May) 1966. (8) Smit, Arne, F., *et al.*: Nordisk Medicin *20*:1260, 1959. (9) Samuels, S. S., and Shaftel, H. E.: JAMA *171*:142-145 (Sept. 12) 1959. (10) Frieh, C., and Olivier, L.: Lyon Med. *91*:891-896 (May 24) 1959. (11) Weghaupt, Von K.: Wien.klin.Wchnschr. *69*:31-32 (Jan. 11) 1957. (12) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960.

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Microphoto of occluded vessels in gangrenous area of a first toe amputated because of severe arteriosclerosis obliterans. Cast was made by injecting acrylic plastic into the vessels. *Used with permission. Courtesy of Margaret C. Conrad, Ph.D., Department of Physiology, Bowman-Gray School of Medicine, Wake Forest College, Winston-Salem, N. C.*

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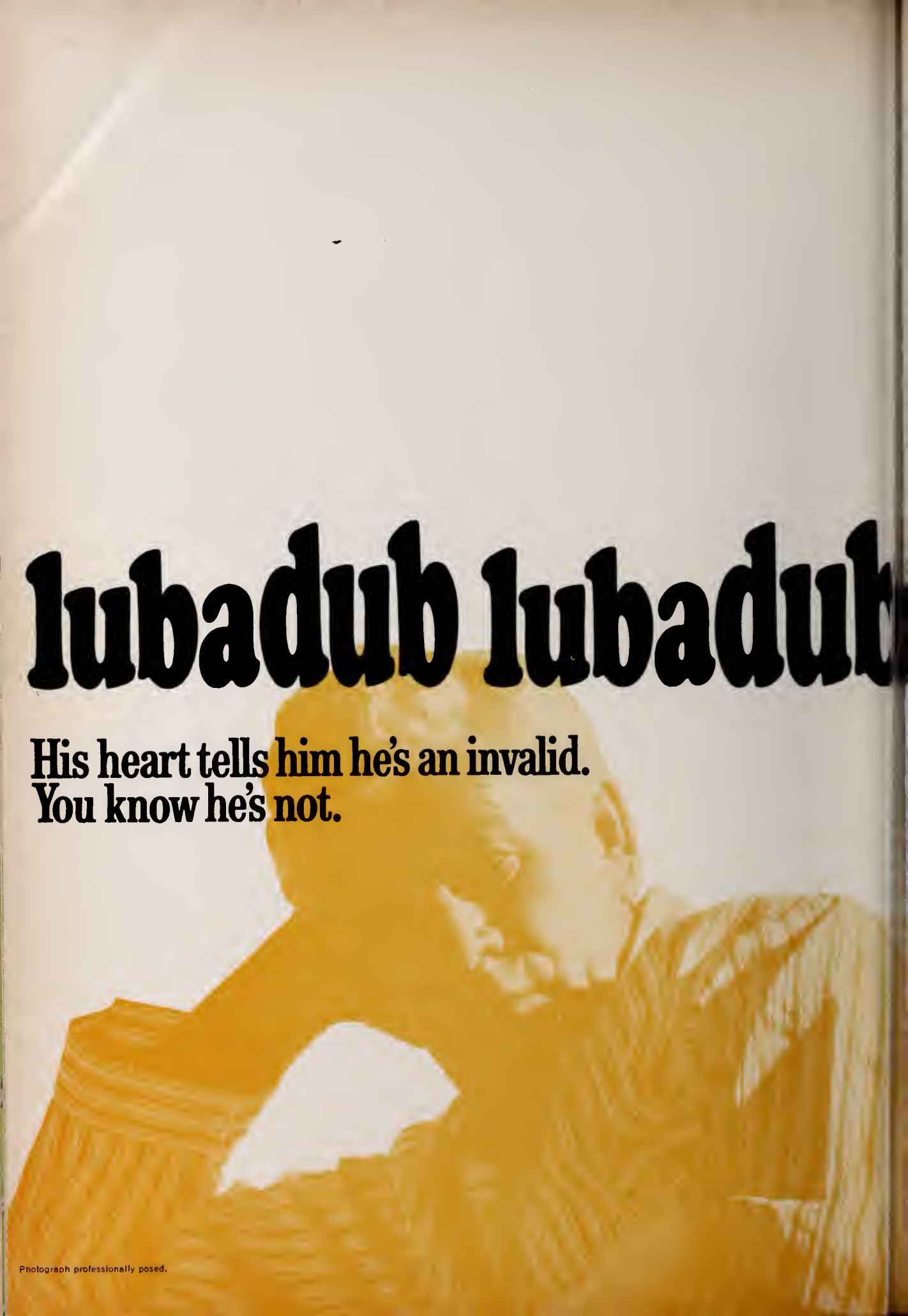
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little may even be desirable.

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terferes with sleep . . . when it aggravates
rdiovascular symptoms, your help may
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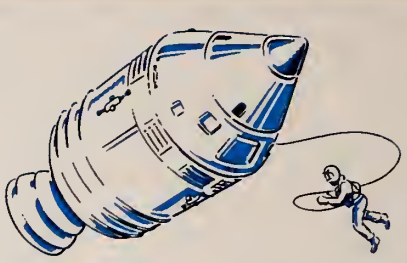
stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

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March 4	"The Hematologic Toxicity of Chloramphenicol. Biochemical and Clinical Significance"	Rafael Lopez, M.D.
March 11	"Abnormal Human Hemoglobins, Their Biochemical Basis, and Clinical Significance"	Anthony Giorgio, M.D.
March 18	"Disorders of Iron Metabolism with Emphasis on the Diagnosis and Treatment of Iron Deficiency"	Rafael Lopez, M.D.
March 25	"Immunoglobulins: The Valve of Immunoelectrophoresis"	Arie Ribon, M.D.
April 1	"Physiopathology of Portal Hypertension"	Herbert Weisberg, M.D.
April 8	"Ultrastructural Aspects of G.I. Diseases"	Herbert Weisberg, M.D.
April 15	"Anatomical Basis of Gastrointestinal Diseases"	Herbert Weisberg, M.D.
April 22	"Neuro-Endocrine Interrelationships"	Leonard Fisher, M.D.
April 29	"The Biological Clock and Its Implications for Human Disease"	Leonard Fisher, M.D.
May 6	"Antigenic Properties of Drugs"	Mario Inchiosa, Ph.D.
May 13	"Anticoagulants"	Sigmund Lasker, Ph.D.
May 20	"The Management of Obesity"	Seymor K. Fineberg, M.D.
May 27	"Hypoglycemia (Etiologies, Diagnosis, and Therapy")	Leonard Fisher, M.D.

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Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

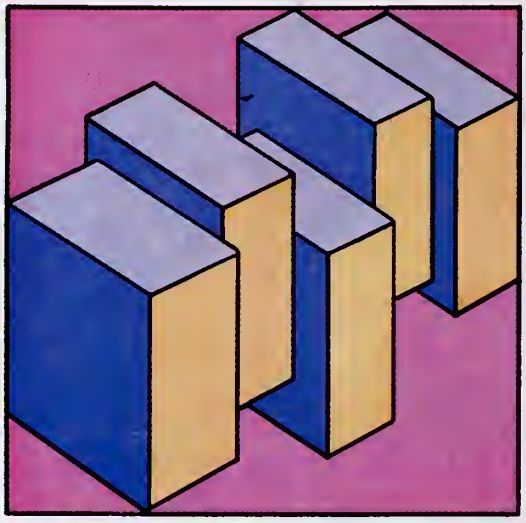
Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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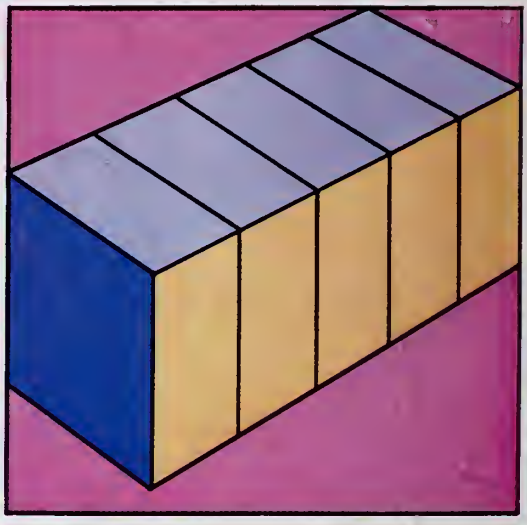
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INDICATIONS: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
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WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
PRECAUTIONS: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
ADVERSE REACTIONS: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido--all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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APRIL 1970
VOL. 67, NO. 4

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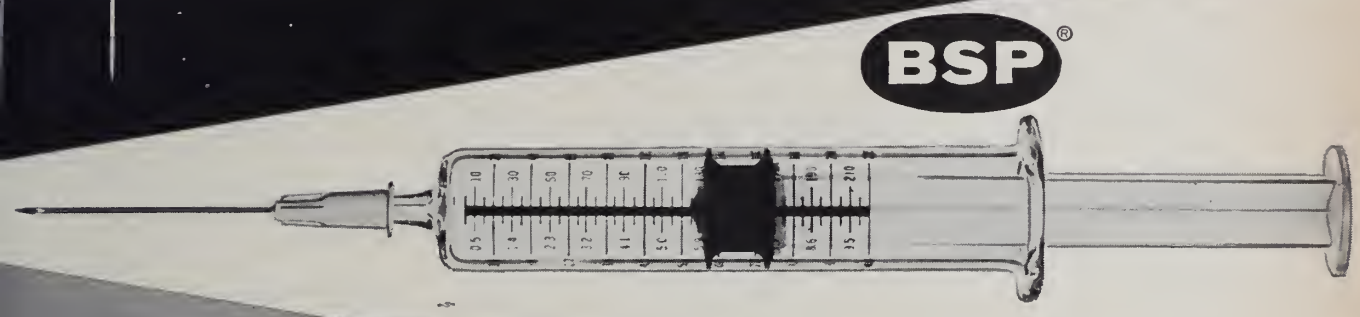
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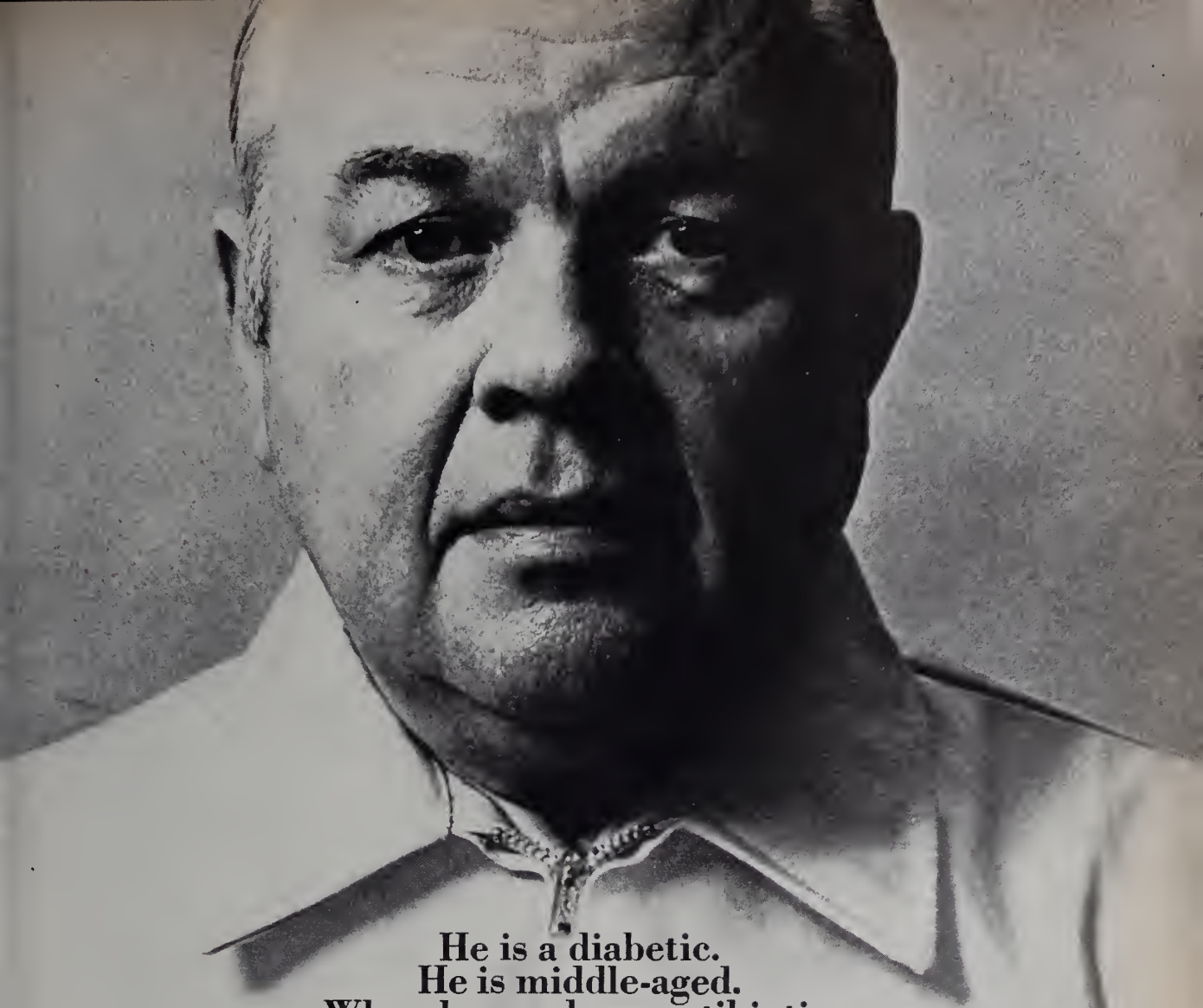
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arning: In renal impairment, usual doses may lead to excessive accum-ation and liver toxicity. Under such conditions, lower than usual doses e indicated, and, if therapy is prolonged, serum level determinations ay be advisable. A photodynamic reaction to natural or artificial sun-ght has been observed. Small amounts of drug and short exposure may oduce an exaggerated sunburn reaction which may range from ery-ema to severe skin manifestations. In a smaller proportion, photo-ergic reactions have been reported. Patients should avoid direct posure to sunlight and discontinue drug at the first evidence of skin scomfort. Necessary subsequent courses of treatment with tetracy-nes should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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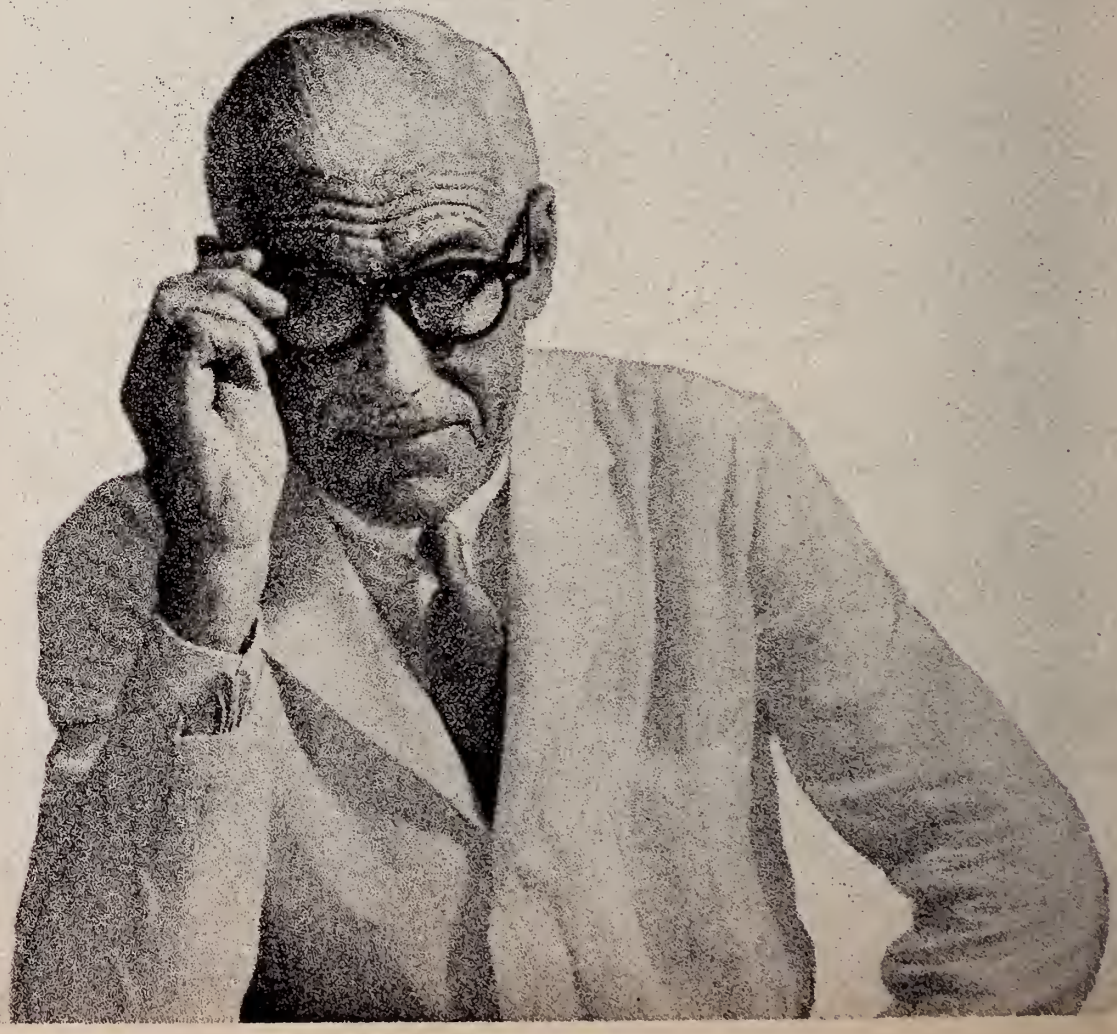
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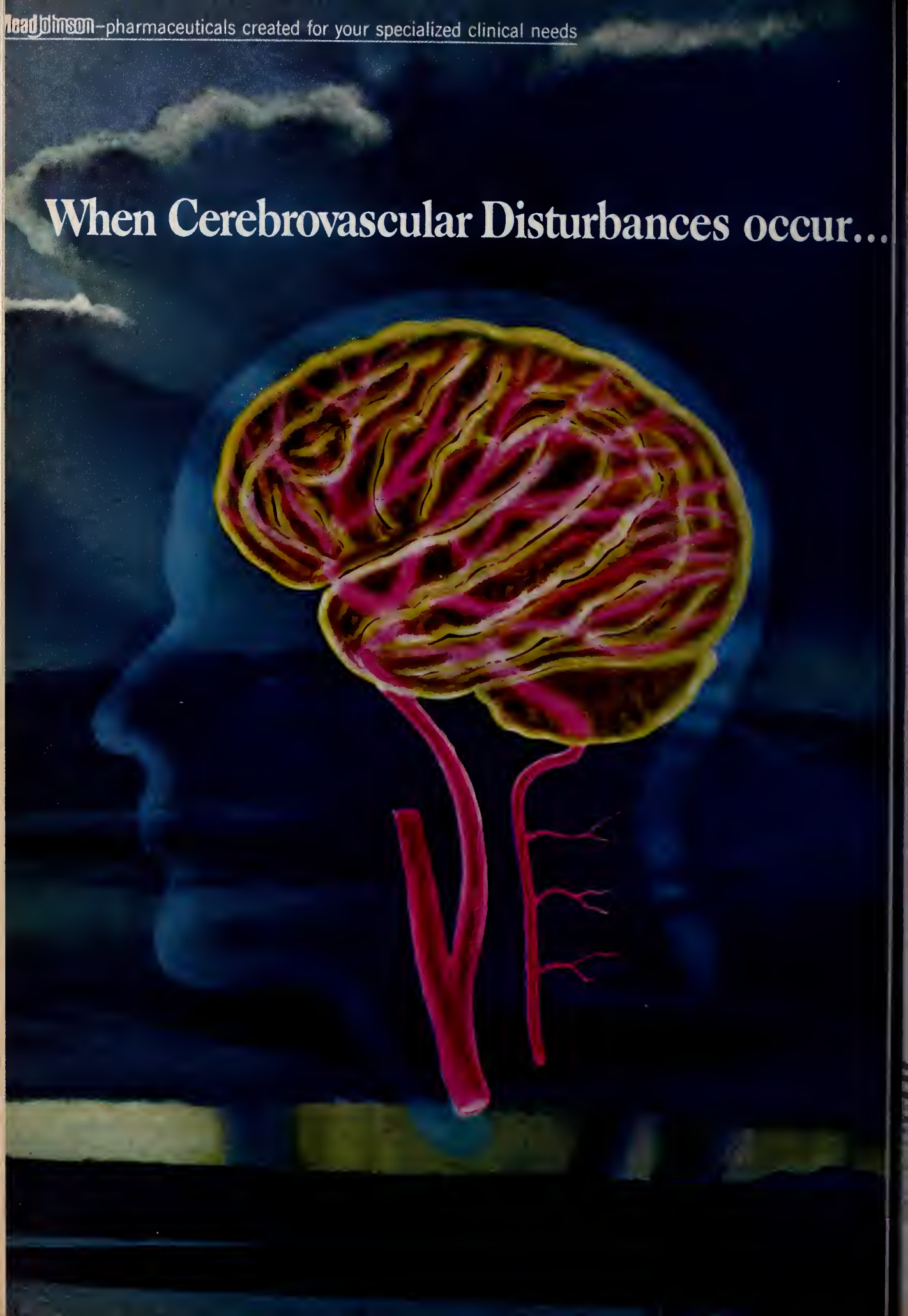
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You might also say that all interns aren't alike, either.



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Obesity may also aggravate osteoarthritis, flat feet, intertriginous dermatitis, varicose veins, and ventral or diaphragmatic hernias.[1-3]

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phenmetrazine hydrochloride
Endurets®
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Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

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One Endurets tablet after breakfast. It helps reduce weight and costs, conveniently.

For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.

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Equivalent to Nicotinic Acid	12.5 mg.
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Vitamin A	2,500 U. S. P. Units
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Thiamine Mononitrate	2.5 mg.
Riboflavin	2.5 mg.
Ascorbic Acid	25.0 mg.
Folic Acid	0.125 mg.
Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
Inositol	10 mg.
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg.
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.25 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 mg.
Magnesium (from Magnesium Sulfate)	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.
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ACTION AND USES—*DOSAGE:* 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. *PRECAUTIONS:* Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. *CONTRAINDICATIONS:* Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. *AVAILABLE:* Bottles of 30, 100, and 500 tablets. Rx only. Also available: Testand-B injection...vials of 10 cc.

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Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

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Painful night leg cramps...

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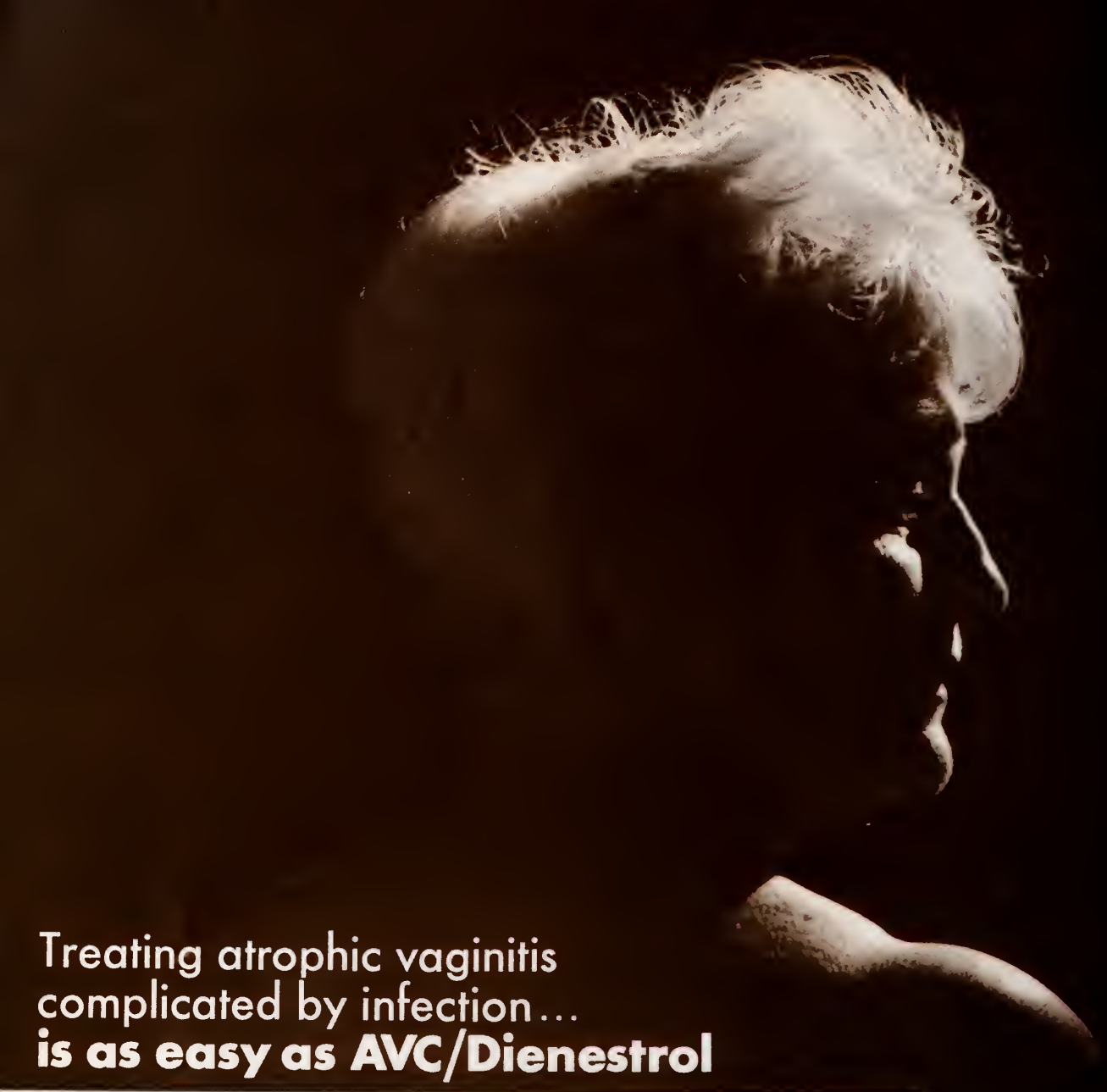
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Compositian: Each white, beveled, compressed tablet cantains: Quinine sulfate, 260 mg., Aminaphylline, 195 mg. **Indications:** Far the preventian and treatment af nacturnal and recumbency leg muscle cramps, including thase assaciated with arthritis, diabetes, varicose veins, thrambaphlebitis, arteriasclerasis and static faat defarmities. **Contraindicatians:** QUINAMM is contraindicated in pregnancy because af its quinine cantent. **Precautions/Adverse Reactions:** Aminaphylline may praduce intestinal cramps in some instances, and quinine may produce symptams af cinchanism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances accur. **Dosage:** One tablet upan retiring. Where necessary, dasage may be increased ta ane tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Dienestrol helps restore estrogen-deficient vaginal mucosa.
It is the *particular* ingredient in AVC/Dienestrol that improves cell maturation counts[1,2] —helps stimulate the restoration of normal vaginal epithelium to resist infection.

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So even in complex cases, the treatment can remain the same. Comprehensive. Effective. Easy as AVC/D.

Contraindications: Known sensitivity to sulfonamides; diagnosis or familial history of carcinoma of the genital tract or breasts; precarcinomatous lesions of the vagina or vulva; palpable uterine fibromyoma; mammary fibroadenoma; depressed liver function.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity or sensitivity are reasons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for careful diagnostic measures to eliminate the possibility of neoplasia of the vulva or vagina. Manifestations of excessive estrogenic stimulation through dienestrol absorption may occur. These include uterine bleeding, breast tenderness, exacerbation of menstrual irregularity and provocation of serious bleeding in women sterilized because of endometriosis. Endometrial withdrawal bleeding may occur if use is suddenly discontinued.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: 'AVC/Dienestrol Cream'—Four ounce tube *with* applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 *with* applicator.

References: (1) Solerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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AVC/Dienestrol

Cream (dienestrol .01%, sulfonilamide 15.0%, aminocrine hydrochloride 0.2%, allantoin 2.0%)
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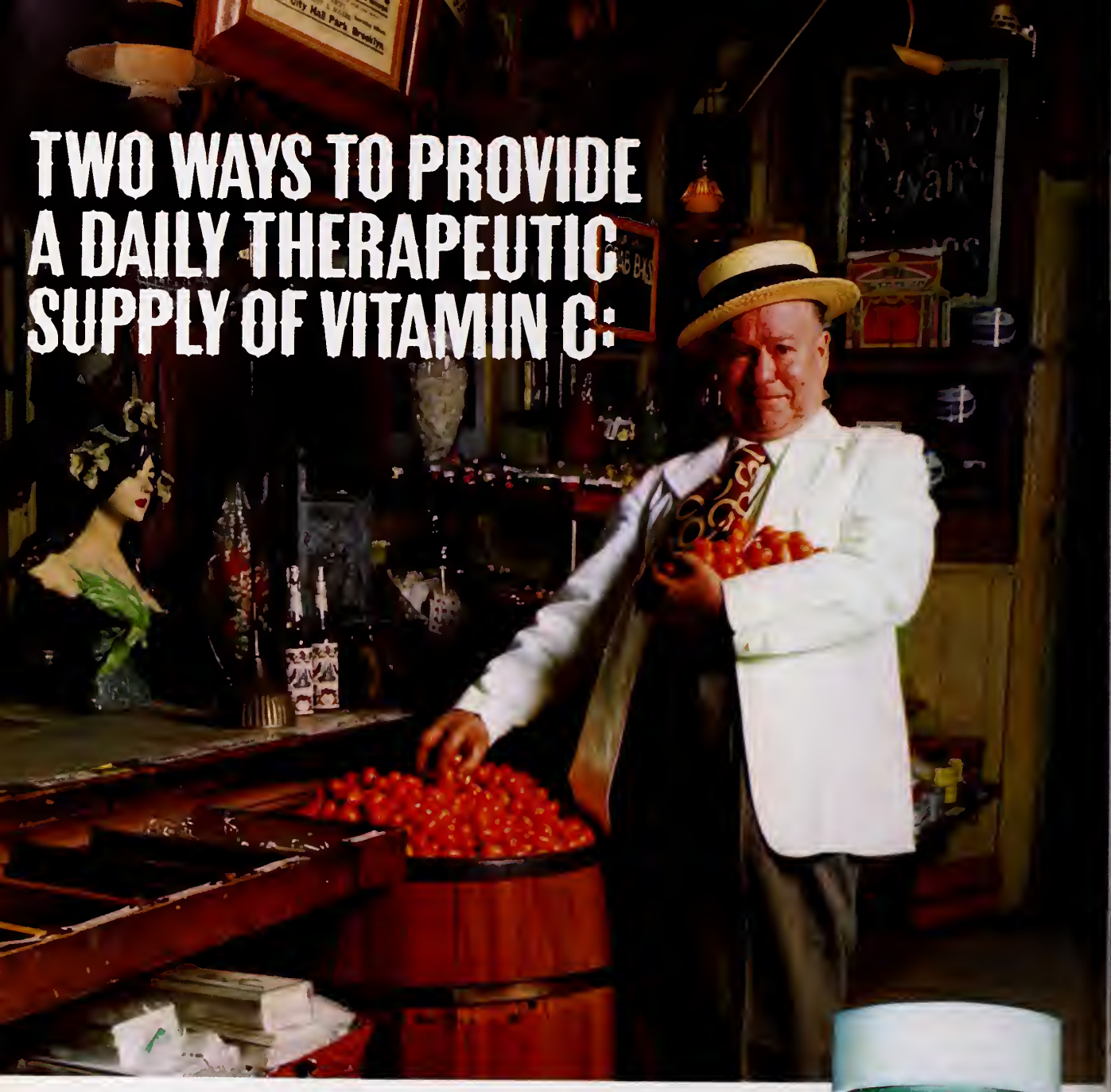
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hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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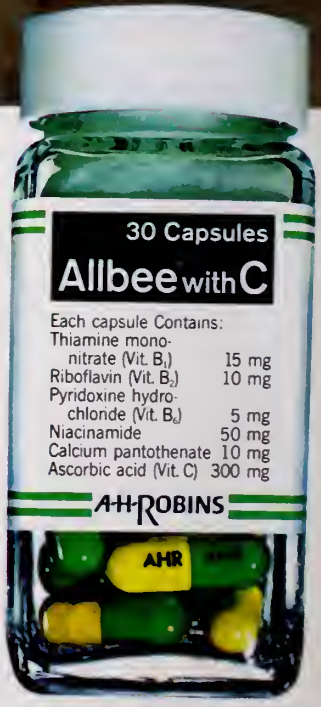


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EDITORIALS

The Forty Days Of Quarantine

Add to the list of fading medical modalities, the forty days of quarantine. That's what the word means: 40 days. Once exposed to pestilence, men and merchandise had to be isolated for 40 days — hence the word *quarantine*. The idea was that some mystic miasma caused the disease, and in 40 days that miasma would somehow be gone with the wind. When a ship came in from other (and therefore suspected) parts it anchored midstream and the merchandise and merchant sailors were checked for disease. If none was found, a "bill of health" was given. Otherwise, the men and the freight remained in an off-shore wooden prison until the 40 days had ended. And when they said isolation in those days, they meant it. Harsh penalties — including hanging — were applied to those who broke quarantine. For the fear of pestilence rode high in the land.

It took some arguing to get nations to honor the "bill of health" of another country. Finally at the International Sanitary Convention of 1851 it was agreed to accept a certified "clean bill of health" for a ship without added quarantine.

Toward the end of the 19th century, the new science of bacteriology began to pull up the shade. Koch's finding of the cholera germ in 1884, for example, opened the door to rational cholera prevention. In 1894 the great plague itself was shown to be due to a bacillus; and the role of rats and fleas and lice in the distribution of the plague was demonstrated. In 1907 came the International Office of Public Hygiene and finally, in 1912, the rationalization of quarantine.

The story might have ended there, since public health knowledge in the 1912-1930 period was advanced enough to remove the need for irrational methods of disease control. But time gave it a new twist, the aeroplane. Now a tropical disease could be carried to a temperate climate in a single night. So new regulations — not a "quarantine" this time — had to be developed. In 1933 came the first International Sanitary Convention for Aviation. And in 1946, the World Health Organization took over the responsibility for framing regulations to prevent disease from leaping the oceans.

So compulsion is now reduced to the three vaccines: small pox, yellow fever, and cholera. Hospitals are available to isolate infected persons. Provisions exist for putting contacts under surveillance, without harsh restriction of liberty. Insecticides have removed much of the fear. Rising living standards have reduced much of the exposure. And tomorrow's medical students may scarcely know the meaning of that once important word: quarantine.

Camp For Diabetic Children

On June 28, 1970 Camp Nejeda will open for its thirteenth season. Nejeda is the New Jersey Diabetes Association's camp, and is run by the New Jersey Diabetes League, a citizens' organization, and the New Jersey Diabetes Association. In the United States diabetic children have available forty camps designed to give them a healthy summer vacation and a sense of security in a group where they can learn to take care of themselves. The New Jersey camp of seventy acres is at Stillwater in Sussex County and includes good swimming facilities, a professional administrative staff, and facilities for medical care and all camping activities. The medical committee has been particularly fortunate in obtaining the services of interns and residents of the Hunterdon Medical Center for the past two years, for a regularly scheduled coverage of the camp under the supervision of the members of the New Jersey Diabetes Association. The committee looks forward to their future participation in conjunction with well qualified registered nurses who are always in attendance.

Every physician in New Jersey should know about (and be proud of) this interesting facility. It is a unique institution for the health and happiness of our children. Tell the parents of diabetic children about Camp Nejeda. Your reward will be the satisfaction that comes with a constructive and helpful health suggestion. The Camp Nejeda office is located at the Academy of Medicine, 317 Belleville Avenue, Bloomfield.

That Personal Touch

A man went to buy a suit the other day in a large, well-stocked, well-advertised men's furnishing store. He had to pull a number from a machine that spewed out tickets. When the loud speaker called "71" a salesman came out and briskly attended to his needs. The man protested that he wanted a more personal kind of interest than that. "Things aren't what they used to be, in these huge modern stores." Then there was the householder who tried to get an electrician to put a floodlight near his front porch. (Guess why). The electrician came in, took a look and sent in an apprentice to do the job in weary, mechanical, distinterested, and (as it turned out) inefficient fashion. Trouble with telephone installations are too well known to warrant recounting here. Almost everyone has a favorite story about the data-processed bills sent in by department stores and the computerized checks and statements that come from other businesses, and the enormous difficulty of talking back to a computer or even getting any reasonable answer at all. Some automobile owners are happy with their repair men but most have the same grievance: no personal attention.

And what's this sad saga doing in a medical journal? Well, a similar complaint is being made about doctors. This missing ingredient in medical care today, it is repeatedly alleged, is human warmth and personal interest. If this *is* true, let it be said that the doctor is not the first or only offender. You are not going to get the intimacy of personal care in a thousand bed medical center that you got in a 100 bed small town hospital. That's also true of bureaucrats in the giant-sized city hall compared with the service rendered by the clerk in the six room township building of a mini-municipality. So, to the complaint of inadequate personal concern we can, at least, plead *non-vult.*

The Biology Of Ecology

One thing about democracy, we all breathe the same air (excluding the cigarette smoker who inhales his private air pollutants). And with urbanization, industrialization, and increasing population, we are getting air that is more and more polluted. Any further study of the biochemistry of man must now include the fact that as today we have DDT in the omentum, strontium in the bones, pesticides in the gastrointestinal tract, iodine in the thyroid, and all sorts of pollutants in the lungs. The combustion of fuels releases sulfur dioxide, so every day we breathe some of *that.* It is hard to escape soot, which too often carries carcinogenic compounds. We are immersed in a sea of hydrocarbons, carbon dioxide (also, believe it or not, carbon monoxide), fluorides, beryllium, and lead.

It is curious that, as physicians, we are so unaware of the chemical barrage by which we are assaulted, yet we resent it when non-physicians advise on health problems. Medicine, after all, is not 100 per cent biology. In addition to the emotions and their destroying (and sometimes, healing) effect, there is the matter of the external environment—of ecology, if you will. It is about time we considered the biology and chemistry of our gaseous, terrestial, and marine environment as something of interest and importance to the physician. This concern for clean air is not just for the birds. An interest in unpolluted water is not something we should tell to the marines. All humans are but fish at the bottom of a sea made up of a weird and wide variety of chemicals. Before we have to migrate out of this world, let's see if we can't do something about making it livable again. If the doctor doesn't take a prime role here, other professions eventually will.

The Medical Society of New Jersey

204th ANNUAL MEETING

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Nicholas A. Bertha, M.D.
President

James A. Rogers, M.D.
Chairman, Annual Meeting Committee

Robert E. Verdon, M.D.
Chairman, Scientific Program

Sidney S. Girsh, M.D.
Chairman, Scientific Exhibits

Marion R. Walton
Convention Manager

May 16-19, 1970
Chalfonte-Haddon Hall
Atlantic City

1970 Annual Meeting

RESUMÉ OF EVENTS

Saturday through Tuesday
May 16 to 19, 1970

Chalfonte-Haddon Hall
Atlantic City

Registration

Saturday, May 16 from 10:00 a.m. to 4:30 p.m. Sunday and Monday, May 17 and 18, from 9:00 a.m. to 4:30 p.m. Tuesday, May 19 from 9:00 a.m. to 3:00 p.m.

Golden Merit Award

Saturday, May 16 at 1:00 p.m. Honored will be those members of MSNJ who have held the degree of Doctor of Medicine for fifty years. Reception following ceremony.

House of Delegates

First Session—Saturday, May 16 at 2:30 p.m.

Second Session—Sunday, May 17 at 3:30 p.m. (Election)

Third Session—Tuesday, May 19 at 9:00 a.m.

General Session

Saturday, May 16 at 3:30 p.m.
Topic: Medicaid

Medical-Surgical Plan

Saturday, May 16 at 4:00 p.m.—Open Discussion Joseph P. Donnelly, M.D., President, MSP, presiding.

Variety Entertainment

Saturday, May 16 at 9:00 p.m.

Mary Mulholland, Vocalist
Clement M. Jones, M.D., Magician
Passaic County Choral Group

Scientific Program

Scientific Section Sessions:

Sunday, May 17 at 9:30 a.m. and at 1:00 p.m.
Monday, May 18 at 9:30 a.m. and at 2:00 p.m.

Special Session

Sunday, May 17 at 10:00 a.m.—Session on Drug Abuse, presented by the New Jersey College of Medicine and Dentistry

Reference Committees

Sunday, May 17 at 11:00 a.m.

(Coffee-Meeting with Chairmen at 10:30 a.m.)

Motion Picture Theatre

Sunday and Monday, May 17 and 18 starting at 10:00 a.m. and again at 2:00 p.m. Tuesday, May 19 at 10:00 a.m. Arranged and presented through the cooperation of the Ciba Pharmaceutical Company of Summit.

Reception for President-Elect

Sunday, May 17, at 6:00 p.m. Members, guests, wives of members and guests, and Auxiliary members are invited to attend a reception honoring the President-Elect, Dr. Emanuel M. Satulsky. (Admission by badge)

Exhibitors Reception-Buffet

Sunday, May 17 at 8 p.m. A special invitation is extended to members, guests, wives of members and guests, and Auxiliary members to attend a reception and buffet honoring technical exhibitors. (Tickets at the Registration Desk—$9 per person)

Dinner-Dance

Monday, May 18 at 7:00 p.m. Members, guests wives of members and guests, and Auxiliary members are invited to attend a dinner-dance in honor of President and Mrs. Bertha. (Tickets at Registration Desk—$11 per person)

Miscellaneous

Saturday, May 16 at 11:00 a.m.—Meeting followed by luncheon, New Jersey Committee on Trauma, American College of Surgeons
Saturday, May 16 at 1:00 p.m.—Annual Trauma Oration, Committee on Trauma, American College of Surgeons
Saturday, May 16 at 5:30 p.m.—Reception, Essex County Medical Society (By invitation only)
Saturday, May 16 at 7:00 p.m.—Officers' Dinner. (By invitation only)
Sunday, May 17 at 8:00 p.m.—Inaugural Dinner (By invitation only)
Monday, May 18 at 12 noon—Luncheon, New Jersey Allergy Society and New Jersey Chapter, American Academy of Pediatrics
Monday, May 18 at 12:30 p.m.—Luncheon, New Jersey Orthopaedic Society
Monday, May 18 at 12:30 p.m.—Luncheon, New Jersey Chapter, American College of Chest Physicians
Monday, May 18 at 4:15 p.m.—Meeting, New Jersey Society of Physical Medicine and Rehabilitation

1970 Annual Meeting

DAILY SCHEDULE

Saturday through Tuesday
May 16 to 19, 1970

Chalfonte-Haddon Hall
Atlantic City

Friday/May 15, 1970

4:00 p.m.—Board of Trustees

Saturday/May 16, 1970

10:00 a.m.—Registration Opens
11:00 a.m.—Meeting and Luncheon, New Jersey Committee on Trauma, American College of Surgeons
1:00 p.m.—Golden Merit Award Ceremony
followed by
Reception for Award Recipients and Their Families
1:00 p.m.—Annual Trauma Oration
New Jersey Committee on Trauma, American College of Surgeons
2:30 p.m.—House of Delegates
3:30 p.m.—General Session: Medicaid
4:00 p.m.—Open Discussion on Medical-Surgical Plan
4:30 p.m.—Nominating Committee
5:30 p.m.—Essex County Reception
(By invitation only)
7:00 p.m.—Officers' Dinner
(By invitation only)
9:00 p.m.—Variety Entertainment: Vocalist, Magician, Choral Group
(All members. official guests and their wives, and Auxiliary members are cordially invited to attend—admission by badge.)

Sunday/May 17, 1970

9:00 a.m.—Registration Opens
9:30 a.m.—Scientific Sessions:
Obstetrics and Gynecology
Rheumatism
10:00 a.m.—Special Session on Drug Abuse
Presented by the New Jersey College of Medicine and Dentistry
(All members, official guests and their wives are invited to attend.)
10:00 a.m.—Exhibits Open
10:30 a.m.—Coffee Meeting with Reference Committee Chairmen
11:00 a.m.—Reference Committees
1:00 p.m.—Scientific Sessions:
Anesthesiology, Otolaryngology
Cardiovascular Diseases
Dermatology, Metabolism
Psychiatry and Neurology (Members of the Woman's Auxiliary are cordially invited to attend this session.)
2:00 p.m.—Motion Picture Theatre
3:30 p.m.—House of Delegates (election)
Addresses by President Bertha and President-Elect Satulsky
6:00 p.m.—Inaugural Reception Honoring President-Elect Satulsky
(All members, official guests, and their wives, and Auxiliary members are cordially invited to attend—admission by badge.)
8:00 p.m.—Inaugural Dinner
(By invitation only)
8:00 p.m.—Reception-Buffet for Technical Exhibitors
(Invitation is extended to members, official guests, their wives, and Auxiliary members — tickets at the Registration Desk, $9 per person.)

Monday/May 18, 1970

9:00 a.m.—Registration and Exhibits Open
9:30 a.m.—Scientific Sessions:
Allergy, General Practice, Pediatrics
Chest Diseases, Surgery
Clinical Pathology, Gastroenterology, and Proctology
Orthopedic Surgery
Radiology, Urology
10:00 a.m.—Motion Picture Theatre
12:00 noon—Luncheon Meeting:
New Jersey Allergy Society and New Jersey Chapter, American Academy of Pediatrics
12:30 p.m.—Luncheon Meeting:
New Jersey Chapter, American College of Chest Physicians
12:30 p.m.—Luncheon Meeting:
New Jersey Orthopedic Society
2:00 p.m.—Scientific Sessions:
Medicine
Ophthalmology
Plastic and Reconstructive Surgery
2:00 p.m.—Motion Picture Theatre
4:15 p.m.—Meeting of New Jersey Society of Physical Medicine and Rehabilitation
7:00 p.m.—Annual Dinner-Dance
(All members, official guests and their wives, and Auxiliary members are cordially invited to attend—tickets at the Registration Desk, $11 per person.)

Tuesday/May 19, 1970

9:00 a.m.—Registration and Exhibits Open
9:00 a.m.—House of Delegates
10:00 a.m.—Motion Picture Theatre
3:00 p.m.—Registration and Exhibits Close

Wednesday/May 20, 1970

8:30 a.m.—Board of Trustees

1970 Annual Meeting

GOLDEN MERIT AWARDS

Saturday, May 16 — 1:00 p.m.

Presiding

Nicholas A. Bertha, M.D., President

Master of Ceremonies

John J. Crosby, Jr., M.D., Chairman, Council on Public Relations

Marshals

Presidents of Component Societies whose members are receiving awards

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years

Recipients For 1970

County	Member
Atlantic	Robert A. Bradley, M.D.
Bergen	Ralph J. Brennan, M.D.
	Roland E. Lueddecke, M.D.
Burlington	Henry B. Decker, M.D.
	Edwin A. Harris, M.D.
	Harry B. Mark, M.D.
Camden	Vincent Del Duca, M.D.
	Lawrence L. Glover, M.D.
	Edward P. Shope, M.D.
	*Salvatore A. Siniscalco, M.D.
Cape May	Millard C. Cryder, M.D.
	John B. Townsend, M.D.
Essex	Joseph Bove, M.D.
	Harrold A. Murray, M.D.
	Arthur G. Solk, M.D.
	Asher Yaguda, M.D.
Hudson	William N. Barbarito, M.D.
	John N. Connell, M.D.
	Perry O. Hall, M.D.
	Louis F. Harter, M.D.
Hunterdon	Fritz C. Simon, M.D.
Mercer	Irwin P. Davenport, M.D.
Monmouth	Kenneth G. Brown, M.D.
	Milton E. Kirkpatrick, M.D.
Ocean	William E. Dodd, M.D.
Passaic	Alfred D. Meneve, M.D.
Union	Stanton H. Davis, M.D.
	Victor duBusc, M.D.

*Deceased

Reception for Recipients and Families Following Ceremony

Annual Trauma Oration

Saturday, May 16 — 1:00 p.m.

The Rational Approach to Abdominal Trauma

Gerald W. Shaftan, M.D., Professor of Surgery, State University of New York, Downstate Medical Center, New York; and Chairman, New York and Brooklyn Regional Committee on Trauma

The New Jersey Committee on Trauma of the American College of Surgeons will present its "Annual Trauma Oration" on Saturday, May 16, during the Annual Meeting of The Medical Society of New Jersey. Dr. Gerald W. Shaftan, Professor of Surgery at NYU will discuss, "The Rational Approach to Abdominal Trauma." Dr. Shaftan is a Fellow of the American College of Surgeons, and belongs to numerous other surgical organizations. He has contributed a large number of articles to the literature in the field of trauma, specifically abdominal trauma.

(All members of The Medical Society of New Jersey and other physicians are invited to attend).

1970 Annual Meeting

VARIETY ENTERTAINMENT

Saturday, May 16 — 9:00 p.m.

Master of Ceremonies

Louis K. Collins, M.D.

Program

Mary Mulholland
Vocalist

Clement M. Jones, M.D.
Magician

Passaic County Choral Group
Fritz F. Adler, M.D.
Sandor A. Levinsohn, M.D.
Irving R. Hayman, M.D.
Joseph R. Jehl, M.D.
Roger C. Laauwe, M.D.
James A. Rogers, M.D.
Ciro S. Tarta, M.D.

1970 Annual Meeting

SPECIAL SESSION

DRUG ABUSE

Sunday, May 17 — 10:00 a.m.

Arranged in cooperation with the New Jersey College of Medicine and Dentistry.

All members, official guests, and their wives, and members of the Woman's Auxiliary are cordially invited to attend

10:00 a.m. / Symposium on Youth and Drug Abuse: What Would You Do? What Would You Say?

An Overview of Drug Use and Misuse
STANLEY EINSTEIN, Ph.D., Coordinator, Drug Abuse Education, Division of Drug Abuse, New Jersey College of Medicine and Dentistry; and Editor, International Journal of Addictions

Summary not received

Role and Responsibility of the Medical Profession
EDWARD A. WOLFSON, M.D., Director, Division of Drug Abuse; and Associate Professor, Department of Public Health and Preventive Medicine, New Jersey College of Medicine and Dentistry

The misuse of drugs is a disturbing and perplexing socio-economic-moral-social-political (and medical) problem that recently has created considerable polarity of public opinion and action. Historically, physicians lack specific training in the "drug scene" and admit to no special expertise in sociology or philosophy; however, "the buck stops here," as the medical profession has been turned to with increasing frequency to solve, advise, and educate.

Physicians must educate themselves on all facets of our pharmacological revolution, insist on strong and active county society committees, and initiate "hot lines" in their localities and relevant curriculum revision in schools—in essence, become "involved" and totally committed.

Amphetamines and Hallucinogens: A Modern Epidemic
SIDNEY COHEN, M.D., Director, Division of Narcotic Addiction and Drug Abuse, National Institute of Mental Health, Chevy Chase, Maryland.

Summary not received

Drug Laws and Enforcement Policies: Is Repression the Answer?
RUFUS KING, Esq., Washington, D.C.

Offered here is a compact review of the major steps (missteps) that turned the mild 1914 Harrison Act tax program into a fierce 1970 federal "war." Repression of drug abuse, by criminal sanctions administered by federal police authorities, is demonstrably not a working or workable solution. There are viable alternatives short of the other, equally deplorable, alcohol-tobacco extreme.

Drug Abuse and Misuse, Whose Responsibility? DONALD B. LOURIA, M.D., Chairman and Professor, Department of Public Health and Preventive Medicine, New Jersey College of Medicine and Dentistry

With the alarming increase in the use and misuse of lethal drugs by youth, both in the ghetto and suburban communities, serious concern has evolved. The question often posed is, "Who's Responsible?" To some the answer seems to lie with law enforcement agencies; others look to the courts and the legislature; still others look to social agencies involved in treatment and rehabilitation. There is a growing concern and cloudiness as to the private physicians' responsibility here. The speaker's central viewpoint, then, is based on the assumption that drug abuse is first a community problem and secondly a personality disorder.

Question and Answer Period
Moderator: EDWARD A. WOLFSON, M.D.

11:45 a.m. / Visit to Exhibits

(All members, official guests, and their wives, and members of the Woman's Auxiliary are cordially invited to attend.)

VISIT THE EXHIBITS

1970 Annual Meeting

General Session

Saturday, May 16 — 3:30 p.m.

Presiding

Nicholas A. Bertha, M.D., President

The New Jersey Medicaid Program

Representative speakers
New Jersey Department of Institutions and Agencies
Prudential Insurance Company of America
Department of Health, Education, and Welfare

Questions and Answers

1970 Annual Meeting

DINNER-DANCE

Monday, May 18 — 7:00 p.m.

Honoring
President and Mrs. Nicholas A. Bertha

Toastmaster

Richard I. Nevin

Welcome

Mrs. Edward O. MacDonald, President
Woman's Auxiliary

Introductions

Mrs. Alexander U. Bertland, President-Elect
Woman's Auxiliary
Emanuel M. Satulsky, M.D., President-Elect
The Medical Society of New Jersey

Presentations

Fellow's Key
To: Nicholas A. Bertha, M.D., President

By: John F. Kustrup, M.D., Immediate Past-President

Fellowette's Pin
To: Mrs. Edward O. MacDonald, President Woman's Auxiliary

By: Nicholas A. Bertha, M.D., President
The Medical Society of New Jersey

Music and Dancing

Martin King Orchestra Associates

1970 Annual Meeting

REFERENCE COMMITTEES

Sunday, 11:00 a.m. May 17, 1970

Reference Committee on Constitution and Bylaws
Pennsylvania II, Lounge Floor

Reports of the:
- Committee on Revision of Constitution and Bylaws
- Amendments to Constitution
- Amendments to Bylaws

Reference Committee "A"
Viking Room, Tower Floor

Reports of the:
- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Director
- Committee on Credentials
- Committee on Admission of Osteopath to MSNJ

Reference Committee "B"
Room 1344, Tower Floor

Reports of the:
- Treasurer
- Committee on Finance and Budget
- Committee on Publication
- Committee on Medical Student Loan Fund
- Committee on Project Hope/Vietnam

Reference Committee "C"
Mandarin Room, Tower Floor

Reports of the:
- Medical-Surgical Plan of New Jersey
- Committee on Medical Defense and Insurance
- Committee on Retirement Plan for Physicians

Reference Committee "D"
Room 1337, Tower Floor

Reports of the:
- Committee on Medical Education
- Committee on Medicine and Religion
- Committee on Emergency Medical Care
- Committee on Traffic Safety

Reference Committee "E"
West Room, Tower Floor

Reports of the:
- Council on Legislation
- Council on Medical Services, and its Special Committee on Occupational Health, Workmen's Compensation and Rehabilitation

Reference Committee "F"
Rutland Room, First Floor

Reports of the:
- Council on Public Relations
- Council on Mental Health, and its Special Committees on:
  - Alcoholism
  - Drug Abuse
  - Emotional Disorders of Childhood and Adolescence
  - Mental Retardation
  - Seizures

Reference Committee "G"
Derbyshire Room, First Floor

Reports of the:
- Council on Public Health, and its Special Committees on:
  - Cancer Control
  - Child Health
  - Conservation of Vision, Hearing, and Speech
  - Environmental Health
  - Maternal and Infant Welfare

Reference Committee "H"
Rowsley Room, First Floor

Reports of the:
- Committee on Annual Meeting, and its Special Committees on:
  - Scientific Exhibits
  - Scientific Program
- Committee on Honorary Membership
- Advisory Committee to the Woman's Auxiliary

Nominations for Emeritus Membership

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

1970 Annual Meeting

HOUSE OF DELEGATES

Saturday, 2:30 p.m. — May 16, 1970
Sunday, 3:30 p.m. — May 17, 1970
Tuesday, 9:00 a.m. — May 18, 1970

President—Nicholas A. Bertha, M.D., Wharton

Secretary—Charles L. Cunniff, M.D., Jersey City

Speaker—Jesse McCall, M.D., Newton

Parliamentarian—Henry A. Davidson, M.D., East Orange

Sessions

Saturday, May 16—2:30 p.m.

First Session

Invocation
Joseph W. Cookson, Associate Pastor
North and Southampton Reformed Church
Churchville, Pennsylvania

Call to Order by the Speaker
Jesse McCall, M.D.

Organization of the House

Transactions of the 1969 House of Delegates

Introduction of Guests and Delegates from Other States

Annual and Supplemental Reports

Proposed Amendments to the Constitution and Bylaws

Resolutions

New Business

Announcements

Sunday, May 17—3:30 p.m.

Second Session

Report of Nominating Committee

Election

(At the conclusion of this session of the House of Delegates the President and the President-Elect each will present his address.)

Tuesday, May 19—9:00 a.m.

Third Session

Reports of Reference Committees

Unfinished Business

Adjournment

(Luncheon Recess—1:00 to 1:30 p.m.)

OFFICES TO BE FILLED BY ELECTION—1970 ANNUAL MEETING

Office	Term	From To	Incumbent and County
President-Elect	1 year	May 1970-May 1971	Emanuel M. Satulsky Union
1st Vice-President	1 year	May 1970-May 1971	E. Vernon Davis Burlington
2nd Vice-President	1 year	May 1970-May 1971	William J. D'Elia Monmouth
Secretary	1 year	May 1970-May 1971	Charles L. Cunniff Hudson
Treasurer	1 year	May 1970-May 1971	Samuel J. Lloyd Mercer
Trustees:			
1st District	3 years	May 1970-May 1973	Francis J. Benz Morris
4th District	3 years	May 1970-May 1973	*Louis F. Albright Monmouth
5th District	3 years	May 1970-May 1973	A. Guy Campo Gloucester

* Ineligible for re-election, having served 3 full terms.

Office	Term	From To	Incumbent and County
Judicial Councilor:	3 years	May 1970-May 1973	Albert F. Moriconi Mercer
3rd District	2 years	Jan. 1971-Dec. 1972	Marcus H. Greifinger Essex
AMA Delegates	2 years	Jan. 1971-Dec. 1972	Frank J. Hughes Camden
	2 years	Jan. 1971-Dec. 1972	John F. Kustrup Mercer
	2 years	Jan. 1971-Dec. 1972	Luke A. Mulligan Bergen
AMA Alternate Delegates	2 years	Jan. 1971-Dec. 1972	Louis F. Albright Monmouth
	2 years	Jan. 1971-Dec. 1972	John J. Bedrick Hudson
	2 years	Jan. 1971-Dec. 1972	Matthew E. Boylan Hudson
	2 years	Jan. 1971-Dec. 1972	Jerome G. Kaufman Essex
Delegates and Alternate Delegates to Other States:			
New York:			
Delegate	1 year	1971 Annual Meeting	Albert F. Moriconi Mercer
Alternate	1 year	1971 Annual Meeting	Josiah C. McCracken, Jr. Atlantic
Connecticut:			
Delegate	1 year	1971 Annual Meeting	†Lloyd A. Hamilton Hunterdon
Alternate	1 year	1971 Annual Meeting	Peter H. Marvel Atlantic
Administrative Councils:			
Legislation:			
2nd District	3 years	May 1970-May 1973	Louis Kosminsky Hudson
3rd District	3 years	May 1970-May 1973	Leonard Rosenfeld Hunterdon
Medical Services:			
2nd District	3 years	May 1970-May 1973	Leonard Brown Bergen
3rd District	3 years	May 1970-May 1973	Karl T. Franzoni Mercer
Mental Health:			
4th District	3 years	May 1970-May 1973	Edward A. Schauer Monmouth
5th District	3 years	May 1970-May 1973	Miles Drake Cumberland
Public Health:			
2nd District	3 years	May 1970-May 1973	Kendrick P. Lance Passaic
3rd District	3 years	May 1970-May 1973	Thomas F. McLaughlin Middlesex
Public Relations:			
3rd District	3 years	May 1970-May 1973	Howard D. Slobodien Middlesex
6th District	3 years	May 1970-May 1973	Edward Foord Burlington
Standing Committees:			
Annual Meeting	3 years	May 1970-May 1973	**Peter H. Marvel Atlantic
Finance and Budget	3 years	May 1970-May 1973	John S. Van Mater Middlesex
Medical Defense and Insurance	3 years	May 1970-May 1973	William J. D'Elia Monmouth
Medical Education	3 years	May 1970-May 1973	John W. Nicholson, III Burlington
	1 year	May 1970-May 1971	†Irving Rollins Essex
Publication	3 years	May 1970-May 1973	**C. Spencer Davison Salem
Woman's Auxiliary Advisory	3 years	May 1970-May 1973	Edward M. Coe Union

† Deceased

**Ineligible for re-election, having served 3 consecutive terms

1970 Annual Meeting

SPEAKERS

Saturday through Tuesday
May 16 to 19, 1970

Chalfonte-Haddon Hall
Atlantic City

Barad, Gerald S., M.D., Flemington
Berney, Ruth V., M.D., East Orange
Bosley, Charles, M.D., Paterson
Bowe, John J., M.D., Paterson
Brancato, Russell W., M.D., Newark
Breen, James L., M.D., Livingston
Bromley, John W., M.D., Paterson
Byrne, Richard J., M.D., Morristown

Chandler, James J., M.D., Princeton
Coester, Frederick G., M.D., Short Hills
Cohen, Philip, M.D., Paterson
Cohen, Sidney, M.D., Chevy Chase, Md.
Cooper, Edward S., M.D., Philadelphia
Cox, Joseph A., M.D., Short Hills

Diener, Samuel, M.D., East Orange
Downes, John J., Jr., M.D., Philadelphia

Einstein, Samuel, Ph.D., East Orange
Enterline, Horatio T., M.D., Philadelphia

Fleischmajer, Raul, M.D., Merion Station, Pa.
Florin, Alvin A., M.D., East Orange

Gelb, Jerome, M.D., Irvington
Glass, Dorothea D., M.D., Philadelphia
Griswold, Merton L., M.D., Plainfield

Hanauer, Lonnie B., M.D., Millburn
Harber, Leonard C., M.D., New York
Hodes, Horace L., M.D., New York
Hopping, Richard A., M.D., East Orange

Jacobitti, Edmund E., M.D., Maywood
Jaffe, Marvin E., M.D., Philadelphia
Jennings, M. Noel, M.D., Long Branch

Kaminetzky, Harold A., M.D., Newark
Kaplan, Emanuel B., M.D., Teaneck
Kaplan, Leopold S., M.D., Highland Park
King, Rufus, Esq., M.D., Washington, D.C.
Koven, Bernard J., M.D., Englewood

Leaman, John C., M.D., Glen Ridge
Lecks, Harold I., M.D., Bala Cynwyd, Pa.
Lerman, Frederick, M.D., Elizabeth
LeRoy, E. Carwile, M.D., New York
Levinson, Gilbert E., M.D., Jersey City
Lightfoot, Robert, M.D., New York
Louria, Donald B., M.D., East Orange
LoVerme, Stephen R., M.D., East Orange

Mackenzie, James, M.D., New Brunswick
Mathis, James L., M.D., New Brunswick

Nicholas, James A., M.D., New York

Parsonnet, Victor, M.D., Millburn
Patti, Joseph C., M.D., Jersey City

Pickar, Gabriel, M.D., Highland Park
Rush, Benjamin, M.D., Newark

Scher, Allan J., M.D., Morristown
Shaftan, Gerald W., M.D., New York
Siegel, Leo H., M.D., Newark
Singer, Milton, M.D., Irvington
Sommer, George N. J., M.D., Trenton
Stokes, Joseph J. Jr., M.D., Philadelphia
Stool, Sylvan E., M.D., Philadelphia

Timmes, Joseph J., M.D., Jersey City
Trotta, Nicholas C., M.D., Ridgewood
Turtz, Myles G., M.D., Cherry Hill

Vaccarino, Frank P., M.D., Brooklyn
Van Praagh, Ian G., M.D., New York

Waksman, Selman, Ph.D., New Brunswick
Weiman, Robert B., M.D., Camden
Weisse, Allen B., M.D., Jersey City
Whittle, George T., M.D., Asbury Park
Wilson, E. Robert, M.D., Paterson
Wolfson, Edward A., M.D., East Orange

1970 Annual Meeting

SCIENTIFIC SECTION OFFICERS

Saturday through Tuesday
May 16 to 19, 1970

Chalfonte-Haddon Hall
Atlantic City

Allergy
CHAIRMAN—Alan G. Posta, M.D., Trenton
SECRETARY—Mary B. Hall, M.D., Trenton

Anesthesiology
CHAIRMAN—Arganey L. Lucas, Jr., M.D., Dover
SECRETARY—Joanne R. Smith, M.D., Glen Rock

Cardiovascular Diseases
CHAIRMAN—Allen B. Weisse, M.D., Jersey City
SECRETARY—Leonard J. Lesniak, M.D., Wayne

Chest Diseases
CHAIRMAN—Walter Nudelman, M.D., Maplewood
SECRETARY—William S. Kelhoffer, M.D., Roselle Park

Clinical Pathology
CHAIRMAN—Philip J. G. Quigley, M.D., Elizabeth
SECRETARY—Joseph P. Greeley, M.D., Westfield

Dermatology
CHAIRMAN—Martin H. Wortzel, M.D., Millburn
SECRETARY—William Cohen, M.D., Trenton

Gastroenterology and Proctology
CHAIRMAN—Benjamin H. Schatman, M.D., East Orange
SECRETARY—Herbert Z. Greenfield, M.D., East Orange

General Practice
CHAIRMAN—Nelson C. Walker, M.D., Hackensack
SECRETARY—Edmund E. Jacobitti, M.D., Maywood

Medicine
CHAIRMAN—Bascom S. Waugh, M.D., Camden
SECRETARY—James G. Dickensheets, M,D., Camden

Metabolism
CHAIRMAN—Lewis Schwartz, M.D., Jersey City
SECRETARY—Jasper Van Avery, M.D., New Brunswick

Obstetrics and Gynecology
CHAIRMAN—Samuel J. Fortunato, M.D., Short Hills
SECRETARY—Caterina Gregori, M.D., Newark

Ophthalmology
CHAIRMAN—I. Allen Chirls, M.D., East Orange
SECRETARY—A. G. Portfolio, M.D., Ridgewood

Orthopedic Surgery
CHAIRMAN—Donald J. Holtzman, M.D., Elizabeth
SECRETARY—L. Arne Skilbred, M.D., Montclair

Otolaryngology
CHAIRMAN—Harvey P. Yeager, M.D., Millburn
SECRETARY—Myles G. Turtz, M.D., South Orange

Pediatrics
CHAIRMAN—C. Prentiss Ward, M.D., Belleville
SECRETARY—Arthur F. Fost, M.D., Belleville

Plastic and Reconstructive Surgery
CHAIRMAN—Stephen R. Lo Verme, M.D., East Orange
SECRETARY—John J. Bowe, M.D., Paterson

Psychiatry and Neurology
CHAIRMAN—Mary Ann Bartusis, M.D., Trenton
SECRETARY—Eugene V. Resnick, M.D., Paramus

Radiology
CHAIRMAN—Leopold S. Kaplan, M.D., Highland Park
SECRETARY—Franklin Wald, M.D., Edison

Rheumatism
CHAIRMAN—Lonnie B. Hanauer, M.D., Millburn
SECRETARY—Joseph M. Marchesano, M.D., Newark

Surgery
CHAIRMAN—James J. Chandler, M.D., Princeton
SECRETARY—Donald K. Brief, M.D., Millburn

Urology
CHAIRMAN—Frederick Lerman, M.D., Elizabeth
SECRETARY—Samuel J. Arnold, M.D., Morristown

1970 Annual Meeting

SCIENTIFIC PROGRAM

Sunday, May 17
Monday, May 18

Scientific Section Sessions

Scientific Section Sessions

Sunday Morning, May 17

Section on:

Obstetrics and Gynecology

Presiding

Samuel J. Fortunato, M.D., Chairman

9:30 a.m. / Ectopic Pregnancy—A Survey of 654 Patients
JAMES L. BREEN, M.D., Director, Department of Obstetrics and Gynecology, Saint Barnabas Medical Center, Livingston; and Associate Professor, Department of Obstetrics and Gynecology, New Jersey College of Medicine and Dentistry

Six hundred fifty-four patients with an ectopic pregnancy seen during a 21-year span were surveyed. The incidence, symptoms, patho-physiology and therapy of the various sites of ectopic pregnancy are discussed.

The need for continuing early diagnosis is highlighted. From 1959 to 1963 more than 500 women in the United States died from ectopic pregnancy. In New Jersey alone there were, in a 9-year period, 38 maternal deaths due to ectopic pregnancy. Twenty-three of these women had never received therapy.

Question and Answer Period

10:00 a.m. / Bleeding During Pregnancy
HAROLD A. KAMINETZKY, M.D., Director, Department of Obstetrics and Gynecology, Martland Hospital Unit, Newark, and Professor and Head, Department of Obstetrics and Gynecology, New Jersey College of Medicine and Dentistry

Summary not received

Question and Answer Period

10:30 a.m. / Multiparous Patient Trap
IAN G. VAN PRAAGH, M.D., Director, Department of Obstetrics and Gynecology, Saint Luke's Hospital Center; and Clinical Professor of Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University, New York

In one decade at the Woman's Hospital (St. Luke's Hospital Center) in New York, there were 422 primary Cesarean sections performed in multiparas. This represented 17 per cent of all Cesareans and 2 per cent of all viable deliveries during that year period. The three commonest indications were dystocia (40.5 per cent), hemorrhage (19.2 per cent), and previous pelvic surgery (18.2 per cent). The remaining 22 per cent were done for fetal distress, Rh sensitization, toxemia, unfavorable past obstetric history, diabetes and post-maturity. The entire series yielded a maternal morbidity of 10.4 per cent, maternal mortality of 0.7 per cent, and a perinatal mortality of 7.1 per cent.

Question and Answer Period

11:00 a.m. / Business Meeting—Election of Officers for 1971

11:15 a.m. / Visit to Exhibits

Section on:

Rheumatism

Presiding

Lonnie B. Hanauer, M.D., Chairman

9:30 a.m. / Recent Advances in Diseases of Muscle
LONNIE B. HANAUER, M.D., Clinical Assistant Professor of Medicine, New Jersey College of Medicine and Dentistry

Within the last two decades there has been a remarkable advance in the understanding of the physiology and pathology of muscle. Electrical and enzyme studies have resulted in improved diagnosis and occasionally in effective treatment. Some newly described exotic conditions will be briefly mentioned and greater emphasis will be given to diagnosis and treatment of more commonly encountered conditions such as polymyositis and polymyalgia rheumatica.

9:50 a.m. / Current Concepts of Scleroderma (Progressive Systemic Sclerosis)
E. CARWILE LEROY, M.D., Assistant Professor of Medicine, College of Physicians and Surgeons, Columbia University, New York

Summary not received

10:20 a.m. / Immune Complex Etiology of SLE
ROBERT LIGHTFOOT, M.D., Instructor of Medicine, College of Physicians and Surgeons, Columbia University, New York, N.Y.

Current evidence suggests that the pathogenesis of acute post-streptococcal glomerulonephritis, systemic lupus erythematosus (SLE), serum sickness and related disorders is due to the presence of circulating, non-precipitable antigen-antibody complexes. The factors predisposing to the formation of such complexes will be reviewed. Clinical data supporting this concept of "immune complex disease" in patients suffering from SLE will be presented. The implications of these findings with respect to modes of therapy will be discussed.

10:45 a.m. / Discussion

11:00 a.m. / Business Meeting—Election of Officers for 1971

11:15 a.m. / Visit to Exhibits

Sunday Afternoon, May 17

Joint Session, Sections on:

Anesthesiology
Otolaryngology

Presiding

Arganey L. Lucas, M.D., Chairman
Section on Anesthesiology
Harvey P. Yeager, M.D., Chairman
Section of Otolaryngology

1.00 p.m. / Problem of Prolonged Endotracheal Intubation
JOHN J. DOWNES, JR., Senior Anesthesiologist, Director of Intensive Care Unit, Children's Hospital of Philadelphia; and Assistant Professor of Anesthesia and Pediatrics, University of Pennsylvania, Philadelphia

On 116 patients prolonged nasotracheal intubation was done with a polyvinyl-chloride tube. The duration of the intubation varied from 24 hours to as long as 42 days. Complications (including two deaths) occurred in eleven of the eighteen patients intubated for obstructive upper airway disease. Of 98 patients intubated for respiratory failure, complications occurred in three. The technic is of value in establishing and maintaining an artificial airway without resorting to tracheostomy in patients who do not have primary obstructive upper airway disease.

1:25 p.m. / Blood Gases and Physiology
JOSEPH A. COX, M.D., Chairman, Department of Anesthesia, Saint Barnabas Medical Center, Livingston

Respiratory failure produces severe derangements of the oxygen and carbon dioxide levels in the blood together with the development of an acidotic state which progresses to death unless intensive corrective measures are instituted.

The physiology of normal acid-base balance is presented together with an explanation as to how it is affected by respiratory failure. The value of arterial blood gas studies is emphasized not only in gauging the severity of illness but also in evaluating the effectiveness of the therapy utilized to correct this life threatening condition.

1:45 p.m. / Tracheotomy in Children
SYLVAN E. STOOL, M.D., Director, Department of Pediatrics-Otolaryngology, Children's Hospital of Philadelphia

Tracheostomy in infants and children presents many special problems related to trachea size and instruments. A method for performing this procedure will be presented and illustrated.

2:10 p.m. / Complication and Problems of Tracheotomy
MYLES G. TURTZ, M.D., Cherry Hill; Department of Otolaryngology, Temple University School of Medicine; and Director, Department of Otolaryngology, St. Christopher's Hospital, Philadelphia

Summary not received

2:30 p.m. / Business Meeting—Election of Officers for 1971

2:45 p.m. / Visit to Exhibits

Section on:

Cardiovascular Diseases

Presiding

Allen B. Weisse, M.D., Chairman

1:00 p.m. / Symposium on Medical-Surgical Problems in Cardiovascular Disease
Selection of Patients for Coronary Arteriography and Revascularization Surgery
RUSSELL W. BRANCATO, M.D., Clinical Professor of Medicine, New Jersey College of Medicine and Dentistry; and Director, Cardiovascular Laboratory, Saint Michael's Medical Center, Newark

Coronary surgery is undergoing a rapid metamorphosis, from the uncertainty of the Vineberg procedure toward a direct anastomotic attack. The saphenous vein bypass graft to the left or right coronary artery is, for the moment, in the ascendant. Microscopic surgical technics utilizing the internal mammaries anastomosed to branches of the left coronary artery have also been successful. The new procedures represent a real breakthrough

with almost complete relief of anginal pain. These procedures will be discussed and instructive films shown.

The Myocardial Factor in Rheumatic Heart Disease
GILBERT E. LEVINSON, M.D., Professor of Medicine, New Jersey College of Medicine and Dentistry; and Associate Director, Thomas J. White Cardiopulmonary Institute, Berthold S. Pollak Hospital for Chest Diseases, Jersey City

The clinical course in patients with rheumatic heart disease, including the outcome of cardiac surgery, is determined not only by the valve damage but also by the state of the myocardium. Recent advances, both in concepts and technics, now permit quantitative evaluation of myocardial contractility. The application of these new principles and methods should facilitate diagnostic, prognostic, and therapeutic decisions.

Surgery for Coronary Heart Disease
VICTOR PARSONNET, M.D., Director of Surgery, Newark Beth Israel Medical Center; and Clinical Associate Professor of Surgery, New Jersey College of Medicine and Dentistry

An aggressive attitude toward the treatment of coronary heart disease has merit in certain situations. There are patients with segmental arterial occlusive disease of the coronary artery, with or without ventricular dysfunction, who will benefit from aorta-coronary bypass and resection of akinetic muscle. Others benefit from internal mammary artery implantation. Angiography is indicated in patients with suspected, as well as those with proved, coronary heart disease. A method of case selection will be discussed and illustrative case material shown.

New Developments in Cardiac Prostheses
JOSEPH J. TIMMES, M.D., Professor of Surgery, New Jersey College of Medicine and Dentistry; and Director of Thoracic Surgery, Berthold S. Pollak Hospital for Chest Diseases, Jersey City

The present status of prosthetic cardiac valvular surgery will be presented. The technic of valve insertion will be reviewed, including the methods used presently as well as the newer concepts and approaches used in research. The advantages and disadvantages of the currently used prosthetic valves will be shown together with new ways that may overcome the disadvantages of the present methods. The author will also describe construction with fascia lata valve grafts used in the mitral area, presently being studied in the research laboratory.

2:45 p.m. / Panel Discussion
Moderator:
ALLEN B. WEISSE, M.D., Associate Professor of Medicine, New Jersey College of Medicine and Dentistry

3:00 p.m. / Business Meeting—Election of Officers for 1971

3:15 p.m. / Visit to Exhibits

Joint Session, Sections on:

Dermatology
Metabolism

Presiding

Martin H. Wortzel, M.D., Chairman
Section on Dermatology
Lewis Schwartz, M.D., Chairman
Section on Metabolism

1:00 p.m. / Familial Hyperlipoproteinemias
RAUL FLEISCHMAJER, M.D., Professor and Head, Section of Dermatology, Department of Medicine, Hahnemann Medical College and Hospital, Philadelphia

Plasma lipoproteins can be separated by means of electrophoresis into four major groups: chylomicra, beta, pre-beta and alpha. Chylomicra and pre-beta lopoproteins contain large amounts of triglycerides while cholesterol is the major component of beta lipoproteins. Chylomicra are associated with exogenous hyper-lipidemias while pre-beta are the expression of endogenous hyperlipidemias, frequently carbohydrate dependent. On the basis of abnormal lipoprotein electrophoresis patterns, five types of familial hyperlipoproteinemias have been recognized. This paper attempts to correlate the chemical composition and metabolism of plasma lipoproteins with abnormal electrophoretic patterns. Genetics, cutaneous xanthomas, clinical picture, plasma lipids and lipoprotein patterns, pathophysiology and treatment will be discussed for each entity.

1:25 p.m. / Porphyrias and Sun Sensitivity Diseases
LEONARD C. HARBER, M.D., Professor of Dermatology, New York University, Bellevue Medical Center Skin and Cancer Unit, New York.

Dermatologic features of erythropoietic and hepatic porphyrias will be presented in terms of their relationsip to photosensitivity. The abnormal biochemical findings in urine, fecal and red blood specimens will be correlated with cutaneous and systemic manifestations. The role of environmental agents such as chlorinated phenols in inducing hepatic porphyria, as well as human and animal studies relating porphyrin absorption spectra and action spectra will be discussed.

1:50 p.m. / Skin Disease in the Diabetic
GABRIEL PICKAR, M.D., Chairman, Department of Medicine, Chief of Diabetic Clinic, Middlesex General Hospital, New Brunswick

Skin diseases particularly associated with diabetes are discussed from the viewpoint of the internist. The susceptibility of the diabetic to skin infections is discussed. Possible factors here are the increased glucose content of the skin, altered immunologic mechanisms, capillary vascular disease, dehydration and cellular nutrition. All these may contribute to this unexplained susceptibilty. The oval pigmented lesion of the lower extremities and

necrobiosis lipoidica diabeticorum are described and their relation to microangiopathy of the skin (dermopathy) is considered. The dermatologic complications related to neuropathy, arterial and arteriolar disease are reviewed. Skin reactions related to insulin and oral hypoglycemic agents are considered, and insulin lipohytrophy, skin allergies and sulfongluria alcohol toxicity are emphasized. Also discussed are carotinosis, xanthoma diabeticorum and skin diseases with increased incidence of diabetes mellitus.

2:35 p.m. / Panel Discussion

3:00 p.m. / Business Meeting—Election of Officers for 1971

3:15 p.m. / Visit to Exhibits

Section on:

Psychiatry and Neurology

Presiding

Mary Ann Bartusis, M.D., Chairman

1:00 p.m. / Symposium on an Understanding of Patients' Marital Unhappiness
Sexual Ignorance in Marital Discontent
GERALD S. BARAD, M.D., Director of Obstetrics and Gynecology, Hunterdon Medical Center, Flemington

Summary not received

Neurotic Interaction in Marriage
RUTH V. BERNEY, M.D., Psychiatrist in Private Practice, East Orange

At this point in cultural evolution the neurotic process is universal. Marital problems are the reflection of underlying personality disturbances in one or both partners. Components of neurotic interaction in marriage are shown in neurotic choice of mate, in reciprocal neurotic patterns, in sexual symptoms, and in problems connected with child rearing. The basic theory of personality formation and the realization that such development is changing throughout an individual's lifetime will be discussed. A comparison of male and female psychologic development will be highlighted in elucidating the marital interaction. Anxieties and fears are exaggerated and distorted by a world of changing values and discordant subcultures. We "act out" our problems on those closest at hand. The hostile-dependent-sado-masochistic interaction is but a facade of deeper internal and interpersonal problems. Case illustrations show how these unhappy unions present themselves as symptoms in every psychiatric category. By first exposing the hostile interplay, and then replaying the forgotten infantile situation, a more mature personality emerges and often helps salvage the marriage.

Sociological Aspects of Present Day Marriage
JAMES L. MATHIS, M.D., Associate Professor of Psychiatry, Rutgers Medical School, Rutgers—The State University, New Brunswick

Marriage is a social institution rooted in the family (not vice-versa) and inseparable from the family. Some of the functions of this institution are: (1) The transmission of culture from generation to generation, (2) The physical and emotional welfare of children, (3) The protection and maintainance of the female, (4) The legalization of sexual acts.

At least seven interrelated social factors are acting concurrently to change the value of these functions, and therefore to alter the sociology of marriage. These will be discussed.

2:15 p.m. / Question and Answer Period

2:45 p.m. / Business Meeting—Election of Officers for 1971

3:00 p.m. / Visit to Exhibits

(Members of the Woman's Auxiliary are cordially invited to attend this session.)

Monday Morning, May 18

Joint Session, Sections on:

Allergy
General Practice
Pediatrics

Presiding

Alan G. Posta, M.D., Chairman
Section on Allergy
Nelson C. Walker, M.D., Chairman
Section on General Practice
C. Prentiss Ward, M.D., Chairman
Section on Pediatrics

9:30 a.m. / Symposium on Recent Advances in Allergy and Immunizations
Immunization Procedures
JOSEPH STOKES, JR., M.D., Emeritus Professor of Pediatrics, School of Medicine, University of Pennsylvania, Philadelphia

Since the original discovery by Jenner that cow-pox could reduce or prevent small-pox, several other viruses that lead to long-lived or permanent protection in man, have been gradually "domesticated." At present, the attenuated virus vaccines against rabies, yellow-fever, measles, mumps, poliomyelitis, and rubella present what may be considered as a mirror, or mirror image, of nature. Attenuated chicken-pox virus may soon join this protective group. Several of these have been used in a single injection by jet-gun without reciprocal interference of the antigens.

Allergy in Office Practice
EDMUND E. JACOBITTI, M.D., Chief, Department of Allergy, Hackensack Hospital

A broad general knowledge of medicine is the first essential for the diagnosis of allergic conditions, and a complete history of each case is necessary. Discussed here will be various forms of allergy—atopy, contact dermatitis, bacterial and physical, food, and serum sickness—with emphasis on diagnosis. Also considered will be food allergies and some do's and don't's in allergic asthma.

The Allergic Child
HAROLD I. LECKS, M.D., Bala Cynwyd; Associate Clinical Professor of Pediatrics, School of Medicine, University of Pennsylvania; and Children's Hospital of Philadelphia

Summary not received

Panel Discussion

11:15 a.m. / Business Meeting—Election of Officers for 1971

11:30 a.m. / Visit to Exhibits

12:00 noon / Luncheon-Meeting—New Jersey Allergy Society and New Jersey Chapter, American Academy of Pediatrics
Reservations: C. PRENTISS WARD, M.D., 16 Dorothea Terrace, Belleville 07109

Joint Session, Sections on:

Chest Diseases

Surgery

Presiding

Walter Nudelman, M.D., Chairman
Section on Chest Diseases
James J. Chandler, M.D., Chairman
Section on Surgery

9:30 a.m. / Changing Indication for Operation in Hiatal Hernia
MILTON SINGER, M.D., Irvington; Associate Attending in Medicine, Newark Beth Israel Medical Center

Discussed here will be therapy directed toward hiatus hernia. Most of these problems relate to the sliding type, and the paper's emphasis will be directed toward this. The great majority of patients can be handled with medical management. An example of an intractable case treated medically with success will be discussed. A minority of patients are intractable to medical therapy and require surgical repair.

9:50 a.m. / Discussant: BENJAMIN RUSH, M.D., Newark

10:05 a.m. / Changing Indications for Operation in Chest Trauma
JAMES MACKENZIE, M.D., Professor and Chairman, Department of Surgery, Rutgers Medical School, Rutgers—The State University, New Brunswick; and Associate Surgeon, Princeton Hospital

Trauma is the greatest cause of death in patients between 18 and 35 years of age. Thoracic injury is second only to head injury as a cause of death from trauma. Most patients with thoracic trauma may be managed successfully without thoracotomy. Indications for thoracotomy in civilian life are often based upon military experience. These principles which have been developed through meticulous analysis of experience in recent wars are generally applicable. With greater availability of well-trained anesthesiologists and surgeons, however, cautious expansion of these indications for thoracotomy seems indicated. Representative cases exemplifying this approach will be presented.

10:30 a.m. / Discussant: GEORGE N. J. SOMMER, M.D., Trenton

10:45 a.m. / A Method of Cholecystectomy and Intra-Operative Cholangiography
JAMES J. CHANDLER, M.D., Attending Surgeon, Princeton Hospital; and Consultant in Surgery, Princeton University Health Services

This is a discussion of a method of cholecystectomy that has proved useful and safe as well as rapid.

A slightly lateral subcostal incision is used. In most cases the rectus muscle is retracted medially, but in some cases, a portion of the rectus muscle is divided. Fine silk is used for ties. Intra-abdominal exploration is done in all cases. A hemorrhoid clamp has proved useful in grasping the gallbladder and in using traction to aid dissection of the cystic duct. The Fogarty cholanciogram catheter has proved to be an excellent tool for intraoperative cholangiography. While waiting for films to be developed, the cholecystectomy is then done from below upwards. The capsule is closed with running chomic catgut. The first assistant uses a broad flat retractor rather than his hand to aid exposure. The abdominal wall is closed in a standard fashion with the drain being brought out an inferior stab wound. Running subcuticular skin closure has resulted in no superficial wound complications.

11:00 a.m. / Discussant: SAMUEL DIENER, M.D., Newark

11:15 a.m. / Business Meeting—Election of Officers for 1971

11:30 a.m. / Visit to Exhibits

12:30 p.m./Luncheon Meeting — New Jersey Chapter, American College of Chest Physicians.
Reservations: Raymond E. Miller, M.D., 1315 West State Street, Trenton 08618

Joint Session, Sections on:

Clinical Pathology Gastroenterology and Proctology

Presiding

Philip J. Quigley, M.D., Chairman
Section on Clinical Pathology
Benjamin H. Schatman, M.D., Chairman
Section on Gastroenterology and Proctology

9:30 a.m. / Differential Diagnosis of Ulcerative Lesions of the Colon
HORATIO T. ENTERLINE, M.D., Professor of Pathology, University of Pennsylvania School of Medicine; and Director of Laboratories of Pathologic Anatomy and Surgical Pathology, Hospital of the University of Pennsylvania, Philadelphia

Summary not received

9:55 a.m. / Proctosigmoidoscopic Differential Diagnosis of Ulcerative Lesions of the Colon and Rectum
RICHARD A. HOPPING, M.D., Chief of Colon and Rectal Surgical Service, Saint Barnabas Medical Center, Livingston

It was not too long ago that the term, "nonspecific ulcerative colitis," comfortably encompassed the problem of diffuse or segmental inflammatory disease of the large bowel in cases where a specific etiologic agent (such as E. histolytica, Shigella, or the tubercle bacillus) had been ruled out. This is no longer the case. Nonspecific granulomatous colitis has been delineated as an entity related to granulomatous enteritis and quite distinct from chronic ulcerative colitis pathologically, clinically, and diagnostically. Therapeutically this is true to a lesser extent. In addition, ischemic colitis has also been defined as a distinct type of segmental colitis.

The problems relating to diagnosis, treatment, and prognosis of these diseases will be discussed.

10:15 a.m. / Ulcerative Lesions of the Colon—Diagnostic and Therapeutic Problems
LEO H. SIEGEL, M.D., Clinical Associate Professor of Medicine, New Jersey College of Medicine and Dentistry; and Director and Attending Gastroenterologist, Department of Medicine, United Hospitals of Newark

The ability to recognize and differentiate grossly the various ulcerative diseases of the colon is of prime importance to the physician. This is based upon knowledge of the pathologic development of these diseases correlated with history taking, physical examination and the picture he sees on sigmoidoscopy. Radiologic and laboratory findings are comforting (when confirmatory), often widening the field of investigation, occasionally misleading and always time consuming. What the physician sees, feels and senses is still paramount. This presentation is designed to sharpen the diagnostic vision of the physician.

10:35 a.m. / Panel Discussion

11:15 a.m. / Business Meeting—Election of Officers for 1971

Section on:

Orthopedic Surgery

Presiding

Donald J. Holtzman, M.D., Chairman
Section on Orthopedic Surgery
John C. Roy, M.D.,
New Jersey Orthopaedic Society

9:30 a.m. / Symposium on Athletic Injuries
The Sound-Slide Program on Athletic Injuries for Coaches of High School Athletes
E. ROBERT WILSON, M.D., Adjunct Attending Orthopedic Surgeon, St. Joseph's Hospital, Paterson

A sound-slide program is offered, based on papers by individual physicians on the prevention, recognition and emergency care of sports injuries. It will be presented in the form of taped lectures accompanied by slides and will serve as a demonstration of the type of program we hope to have available for the coaches throughout the state within the next year or two. The purpose of this is to show what is available.

Football Injuries and the New York Jets
JAMES A. NICHOLAS, M.D., Clinical Associate Professor of Surgery (Orthopedics), Cornell University Medical College; and Team Physician, New York Jets, New York

This talk will emphasize ten years of experience with professional football injuries with the New York Jets (and Titans). Illustrative material and film clips will show diagnosis, treatment, and end results of common football injury. From this the author will develop general principles on the common causes of injury and their prevention, and to emphasize early recognition and treatment, especially in adolescents and young adults.

Panel Discussion
Moderator: WILLIAM J. D'ELIA, M.D., Spring Lake

Coffee Break

Follow-up Review of Sliding Nails for Hip Fractures
CHARLES BOSLEY, M.D., Resident in Orthopedic Surgery, St. Joseph's Hospital, Paterson

JOHN W. BROMLEY, M.D., Associate Attending Orthopedic Surgeon, St. Joseph's Hospital, Paterson

PHILIP COHEN, M.D., Associate Attending Orthopedic Surgeon, St. Joseph's Hospital, Paterson

Summaries not received

Anterior Lumbar Arthrodesis
FRANK P. VACCARINO, M.D., Director, St. Charles Orthopedic Division Catholic Medical Center, Brooklyn-Queens; and Attending Orthopedic Surgeon, Hospital of the Holy Family, Brooklyn

Summary not received

11:30 a.m. / Business Meeting—Election of MSNJ Section Officers for 1971

11:45 a.m. / Visit to Exhibits

12:30 p.m. / Luncheon: New Jersey Orthopaedic Society
Reservations: JOHN C. ROY, M.D., 41 Elm Street, Morristown 07960

Joint Session, Sections on:

Radiology
Urology

Presiding

Leopold S. Kaplan, M.D., Chairman
Section on Radiology
Frederick Lerman, M.D., Chairman
Section on Urology

9:30 a.m. / Symposium on Current Concepts in the Diagnosis and Treatment of Urologic Neoplasms
Radiological Diagnosis
RICHARD J. BYRNE, M.D., Associate Radiologist, Morristown Memorial Hospital
Radiotherapy
ALLAN J. SCHER, M.D., Director of Radiotherapy, Morristown Memorial Hospital

Here demonstrated are diagnostic procedure indications, hazards, successes and failures. Also discussed are prognostic implications from information obtained from retrograde pyelogram, angiography, lymphography, the I.V.P., and isotope scanning. Therapeutic modalities, indications and results of treatment of renal cell, bladder, prostatic and testicular malignancies are assessed. Methods of monitoring effectiveness of therapy and patient progress are evaluated.

Chemotherapy
BERNARD J. KOVEN, M.D., Englewood; Assistant Professor of Clinical Medicine and Director, Oncology Division, Department of Medicine, New Jersey College of Medicine and Dentistry; and Assistant Attending, Department of Medicine, Memorial Sloan-Kettering Cancer Center, New York

Surgery and radiation therapy remain the primary approaches toward control of neoplasms of the genitourinary tract. Until recent years, chemotherapy was largely ineffective in palliation of disseminated cancers arising from these primary sites. However, to a limited extent, some useful agents are now available which may produce temporary palliation in advanced cancers of the kidney, testis and prostate. The paper will discuss clinical application of these drugs.

Urological Surgery
GEORGE T. WHITTLE, M.D., Attending Urologist, Monmouth Medical Center, Long Branch

Summary not received

Panel Discussion

11:15 a.m. / Business Meeting—Election of Officers for 1971

11:30 a.m. / Visit to Exhibits

Monday Afternoon, May 18

Section on:

Medicine

Presiding

Bascom S. Waugh, M.D., Chairman

2:00 p.m. / Symposium on the Comprehensive Care of the Stroke Patient
Moderator:
ALVIN A. FLORIN, M.D., Clinical Assistant Professor of Medicine, New Jersey College of Medicine and Dentistry; and Assistant Attending Physician in Medicine, East Orange General Hospital

The Practitioner and His Responsibility in Preventing Strokes
ROBERT B. WEIMANN, M.D., Attending Physician, The Cooper Hospital, Camden; and Instructor in Surgery, University of Pennsylvania School of Medicine, Philadelphia

There has been a marked change in the care of the stroke patient brought about by interested and aggressive physicians in all fields of medicine. The primary hope in such an investigative program is in stroke prevention. Diagnosing and treatment of the transient ischemic attack are discussed in conjunction with symptomatology and the related pathologic problems. The current results of a moderate experience in corrective carotid surgery at a general community hospital will be presented.

The Physician's Responsibility in the Treatment of Acute Stroke
MARVIN E. JAFFE, M.D., Neurologist and Assistant Attending Physician, Stroke Research Center, Philadelphia General Hospital; and Instructor in Neurology, Jefferson Medical College, Philadelphia

The first obligation of the physician in management of the acute stroke patient is the preservation of vital functions, while a specific diagnosis is reached. Level of consciousness on admission and associated illnesses are important factors, both in planning management and anticipating prognosis.

The most important immediate measures consist of maintaining adequate ventilation and cerebral blood flow, especially by supporting blood pressure. The indications for diagnostic measures such as spinal tap, electroencephalography, brain scan, and angiography will be discussed, as will their limitations. The patho-physiology of the cerebral circulation in acute stroke, as applied to management, will be presented.

Medical Complications in the Stroke Patient
EDWARD S. COOPER, M.D., Chief, Medical and Cardiac Section, Stroke Research Center, Philadelphia General Hospital; and Assistant Professor of Medicine, University of Pennsylvania School of Medicine, Philadelphia

Broad reference will be made first to the general medical problems and management in stroke patients, including both acute and long-term care. Special emphasis will be given to the following two areas: (1) Determinants of prognosis in stroke patients, and (2) Stroke and hypertension, including reference to a national cooperative study. For the adequate management of both long-term and short-term problems, these patients need versatile physicians.

Prevention of stroke should be our ultimate aim, and prevention involves mainly the control of hypertension, atherosclerosis and heart disease, with a comprehensive medical approach.

The Duties and Responsibilities of the Practicing Physician in the Rehabilitation of the Stroke Patient
DOROTHEA D. GLASS, M.D., Associate in Physical Medicine and Rehabilitation, Albert Einstein Medical Center; and Director of Residency Training in Physical Medicine and Rehabilitation, Temple University School of Medicine, Philadelphia

The physician treating the patient who has sustained a catastrophic stroke (with resultant hemiplegia and/or aphasia and perceptual loss) is responsible for the initiation and direction of an orderly and appropriate program which will enable the patient to progress from dependency to the optimum function possible in view of the residual neuromuscular deficit. We will discuss determination of the appropriate institution and management of suitable exercise programs, bowel and bladder retraining, problems of cardiopulmonary and vasomotor control, use of assistive devices, treatment of spasticity and contractures, common complications, psychosocial adjustment, vocational rehabilitation.

3:20 p.m. / Question and Answer Period

4:15 p.m. / Business Meeting—Election of Officers for 1971

4:30 p.m. / Visit to Exhibits

Section on:
Ophthalmology

Presiding

I. Allen Chirls, M.D., Chairman

2:00 p.m. / Symposium on Fluorescein Angiography

Photocoagulation of Retinal Diseases
JOHN C. LEAMAN, M.D., Director, Retinal Service and Attending Surgeon, Eye and Ear Division, United Hospitals of Newark; and Assistant Clinical Professor of Surgery, New Jersey College of Medicine and Dentistry

Discussed here will be the treatment of retinal conditions using the laser and zenon photo-coagulator. Diabetic retinopathy will receive special consideration. Macula degeneration and various vaso-proliferative conditions will be discussed. Many of these are quite common, and their early evaluation and subsequent handling seem to have a definite bearing on the preservation of vision.

Fluorescein Angiography
NICHOLAS C. TROTTA, M.D., Clinical Associate, Department of Ophthalmology, Mount Sinai School of Medicine and Medical Center, New York

Here presented will be a review of fluorescein angiography, including concepts regarding the factors influencing it and a discussion of the local and systemic diseases in which it occurs. The author will review our present knowledge with some original personal observations and a critique of those of others.

The Natural History of Diabetic Retinopathy
JOSEPH C. PATTI, M.D., Instructor, Department of Surgery, Division of Ophthalmology, New Jersey College of Medicine and Dentistry; and Coordinator, Residency Program, Eye and Ear Division, United Hospitals of Newark

Diabetic retinopathy has become one of the leading causes of blindness in this country. An understanding of the natural history of this condition is essential before direction can be given in its management. Offered here is a discussion of the course of this disease from the formation of microaneurysms to the development of neovascular

changes. The ultimate evolution of retinitis proliferans and retinal detachment will be presented.

Fluorescein angiography of the various stages of diabetic retinopathy will be demonstrated. The importance of study and follow-up utilizing this technic will be described.

Panel Discussion

4:15 p.m. / Business Meeting—Election of Officers for 1971

4:30 p.m. / Visit to Exhibits

Section on:

Plastic and Reconstructive Surgery

Presiding

Steven R. LoVerme, M.D., Chairman

2:00 p.m. / Symposium on Modern Trends in Plastic Surgery—Hand Surgery

Functional Anatomy of the Hand
EMANUEL B. KAPLAN, M.D., Teaneck; Former Clinical Associate Professor of Anatomy, Columbia University College of Physicians and Surgeons; and Consultant, Orthopedic Surgery and Hand Surgery, Hospital for Joint Diseases and Medical Center, New York

In severe involvement to the carpometacarpal joint of the thumb, when the process extends to the trapezoid and to the scaphoid bones, the removal of the trapezium is preferable to fusion of the carpometacarpal joint. This is accomplished through a posterior approach over the anatomical snuff box between the extensor pollicis longus and the abductor pollicis longus tendons. This presents certain difficulties requiring fragmentation of the trapezium.

The author presents a method of removal through the base of the thenar eminence with description of the anatomical structures. Attention is drawn to the errors to be avoided.

Early Revision of the Acutely Injured Hand
JEROME GELB, M.D., Irvington; Attending in Plastic Surgery, Newark Beth Israel Medical Center; and Assistant Clinical Professor of Plastic Surgery, New Jersey College of Medicine and Dentistry

Frequently, it is difficult to determine viability of skin when the injured hand is first seen for emergency treatment. Other times, closure is performed which requires early revision of the wound using all available methods of closure to obtain a covered wound as soon as possible. This decreases the morbidity of the acutely injured hand and hastens the time interval for reconstructive surgery. Cases are presented illustrating this "early revision."

Treatment of Avulsion Injuries of the Hand
JOHN J. BOWE, M.D., Senior Attending Plastic Surgeon, St. Joseph's Hospital, Paterson

Avulsion injuries of the hands are discussed in this paper. The pathology is described. Wringer and roller type machines are frequent agents of these disabilities. Industrial and home agents of injury and the severity of deformity are considered.

Treatment is surgical, both operative and conservative. Multiple illustrative cases are shown portraying the definitive care of these potentially crippling wounds. The rehabilitation of extensive hand injury with appropriate plastic surgery is demonstrated.

Treatment of Digital Loss
MERTON L. GRISWOLD, M.D., Attending in Plastic Surgery, Muhlenberg Hospital, Plainfield

The rotary blade lawnmower and other industrial cutting devices have resulted in an increasing number of partial digital amputations requiring emergency care. For the skilled worker, impaired tactile sense or a stiff finger is a disaster. The author has reviewed results in 29 selected cases, some of which were repaired several years before utilizing current methods of repair. Criteria such as 2 point tactile sensation, use or non-use of the amputated portion and period of disability are weighed in an effort to find the most appropriate method for the individual case.

Tendon Repair
FREDERICK G. COESTER, M.D., Short Hills; Associate Attending and Teaching Service, Saint Barnabas Medical Center, Livingston

Summary not received

Role of the Physiatrist in Hand Problems
M. NOEL JENNINGS, M.D., Chief of Physical Medicine and Rehabilitation, Monmouth Medical Center, Long Branch

Summary not received

Summation of Trends in Treatment of Hand Injuries
STEPHEN R. LoVERME, M.D., East Orange; Associate Clinical Professor, Division of Plastic Surgery, New Jersey College of Medicine and Dentistry

This is a summary of the papers presented and a presentation of other present-day concepts in the treatment of avulsion injuries by various grafts, flaps—local and distant—and by neurovascular pedicle flap; treatment of acute tendon injuries at various sites, immediate or delayed; use of silastic in tendon and nerve repairs; amputations; prevention and treatment of edema of the hand via compression; and dynamic splinting of the hand.

4:15 p.m. / Business Meeting—Election of Officers for 1971

4:30 p.m. / Visit to Exhibits

1970 Annual Meeting

MOTION PICTURE THEATRE

Sunday, May 17	2:00 p.m.
Monday, May 18	10:00 a.m. and 2:00 p.m.
Tuesday, May 19	10:00 a.m.

Arranged and presented through the cooperation of the Ciba Pharmaceutical Company, Summit.

Diagnosis and Treatment of Sedative Overdosage

Joel B. Mann, M.D., Associate Professor of Medicine; Noble David, M.D., Associate Professor of Neurology; Joseph H. Davis, M.D., Professor of Legal Medicine and Medical Examiner, Dade County; and Jerome Modell, M.D., Associate Professor Anesthesiology and Director, Intensive Care Unit, University of Miami, School of Medicine.

This teaching film stresses diagnosis—even differential diagnosis—and management of sedative—analgesic—tranquilizer overdosage. The following "10 Commandments" are emphasized:

1. Secure a free airway immediately and maintain it.
2. Provide for adequate ventilation.
3. Use oxygen as required.
4. Do not use CNS stimulants.
5. Promptly insert a VCP Catheter.
6. Treat hypotension with volume expanders and avoid pressor agents.
7. Perform gastric lavage.
8. Induce an alkaline osmotic diuresis.
9. Carefully observe fluid, electrolyte, pH, and blood gas homeostasis.
10. Avoid decubiti and thrombosis.

Differential Diagnosis of Chest Pain

Presented through the courtesy of Warner-Chilcott Laboratories

Designed as an instructional aid, this film presents practical steps for the differential diagnosis of angina pectoris-like chest pain. The means for eliciting a meaningful patient history is introduced wth lecture material and emphasized by dramatized physician-patient interviews. Relevant physical examination procedures and their rationale are discussed, as is the relationship of angina pectoris to antherosclerosis and ischemic heart disease. The film is limited to diagnosis and does not touch on treatment either environmental or chemotherapeutic.

The Hyperactive Child

Presented througt the courtesy of Ciba Pharmaceutical Company

This film deals with the problem of diagnosing, evaluating, and treating hyperactive children. Involved in this film are pediatricians, child psychiatrists, psychologists, educators, and speech therapists. Various segments were filmed in California, the East Coast, and in London. Among the participants in the United States are Sydney Adler, M.D., Alice Thompson, Ph.D. and Marianne Frostig, Ph.D. in California; and Leon Eisenberg, M.D. of Boston; and Eric Denhoff, M.D. and Harold Laufer, M.D. of Providence.

Implanted Pacemaker, Clinical Evaluation and Elective Replacement

Victor Parsonnet, M.D., Newark Beth Israel Hospital

Impending pacemaker failure can be detected by external electronic testing in a pacemaker clinic. The rate of change of various aspects of the amplified electrical stimulus is determined. The impulse, repetition rate, pulse width, amplitude, and configuration are measured. The pacemaker is replaced when these parameters begin to change significantly. The surgical technic for pacemaker replacement is demonstrated.

Permanent Transvenous Pacing of the Heart

Victor Parsonnet, M.D., Newark Beth Israel Hospital

The author's technic for both interim and permanent pacing of the heart with transvenous catheters is shown, using a patient for the rest of the purposes, from the time of admission to the hospital in complete heart block and Stokes-Adams seizures to the time of his discharge with a permanent transvenous unit. The film includes cineangiograms illustrating proper positioning of the catheter, and animation illustrating the concepts to unipolar and bipolar intracardiac pacing on a long and short term basis. This technic has been used on a permanent basis in 35 patients, and on an interim basis in 220 patients.

Someone Is Watching (Careless Handling of Narcotics)

Produced by the New York State Department of Health

The aim of this film is to call attention to the many ways in which legal narcotics fall into the hands of "dope" addicts and peddlers through carelessness and false confidence, and to re-emphasize the need for diligent safeguarding of drugs.

Treatment of Venereal Disease

Presented through the courtesy of Pfizer Laboratories

This latest Postgraduate Seminar deals with venereal disease—one of the most acute medical and social problems of our time, and one for which the solution depends, in part, on fuller cooperation between the medical profession and public health agencies. In this presentation six eminent authorities discuss the epidemiology, pathogenesis, diagnosis and current therapy of syphilis and gonorrhea.

1970 Annual Meeting

INFORMATIONAL EXHIBITS

Sunday, May 17—10 a.m. to 5 p.m.
Monday, 18—9 a.m. to 5 p.m.
Tuesday, May 19—9 a.m. to 3 p.m.

Rutgers Psychiatric Institute

Albert J. Silverman, M.D., Department of Psychiatry, Rutgers Medical School, New Brunswick

Shown here is a model of the Rutgers Psychiatric Institute and Community Mental Health Center. This will serve 200,000 citizens of Dunellen, Edison, Highland Park, Metuchen, Middlesex, New Brunswick, North Brunswick, Piscataway, and South Plainfield.

Camp Nejeda—New Jersey's Only Camp For Children With Diabetes

Alfred E. Gras, M.D., New Jersey Diabetes Association, Belleville

Here you will see illustrated by maps, pictures, and brochures (available to viewer) the geographical location, the anatomy of the camp, its physical plant, and some of its activities.

The Society for The Relief of Widows and Orphans of Medical Men of New Jersey

James E. D. Gardam, M.D., Belleville

This is an informational exhibit outlining the aims and purposes of a charitable organization which provides for the health and welfare of widows and orphans of deceased members of the Society.

Academy of Medicine of New Jersey

Robert H. Areson, M.D., Montclair

The Academy of Medicine is New Jersey's premier medical educational agency. It is also the locus of the largest medical library in our state. In its graduate educational program it enjoys the support of The Medical Society of New Jersey. This exhibit reviews the Academy's 1969-1970 educational program, highlighting its role as the scholarship headquarters of New Jersey medicine.

Bureau of Children's Services

James B. Butler, M.D., New Jersey State Department of Institutions and Agencies, Trenton

Offered here are interesting photographs showing seven major programs: foster care, adoption, day care, protective services, group care, family counseling, and services to adolescents.

New Jersey Rehabilitation Commission

Jarvis M. Smith, M.D. and Arthur J. Sinclair, Trenton

This exhibit highlights the Vocational Rehabilitation Process and the services of the New Jersey Rehabilitation Commission.

Occupational Health, Workmen's Compensation and Rehabilitation

MSNJ's Committee on Occupational Health, Workmen's Compensation and Rehabilitation

Here is an exhibit which vividly shows some problems related to Occupational Health, to Workmen's Compensation, and to Rehabilitation.

New Jersey Air Pollution Control

New Jersey State Department of Health, Trenton

This major exhibit briefly offers a "status report" on air pollution control in New Jersey. One section bears the legend "How's the Air in Newark Now?" This contains three large air pollution monitors which continuously record the levels of sulfur dioxide, carbon monoxide and smoke in the city of Newark. The exhibit is hooked into the New Jersey Air Monitoring System. A monitoring unit, operating continuously in Newark, telemeters contaminant levels to air pollution control headquarters in Trenton. The electronic pulse is then relayed to the exhibit by telephone line.

The rest of the exhibit shows the following:

(a) Sources of air pollution under control in New Jersey, a series of back-lighted, full-color photographs, each depicting a source and illustrating the pertinent regulation;

(b) An artistic rendition of the auto rapid test system now in prototype stage in New Jersey; and

(c) A theme center showing New Jersey's clean air and water trademark, or poster.

Radiological Health Program

Eugene E. Cioffi, M.D., New Jersey State Department of Health, Trenton.

Shown here are instructive color transparencies dealing with medical x-ray protection.

New Jersey Regional Medical Program

Here offered is a report on the status of the New Jersey Regional Medical Program's operational projects and on-going planning activities in heart disease, cancer, stroke, and related diseases.

Your Medical Assistant

American Association of Medical Assistants, Inc., State of New Jersey

For your information and interest there is here offered a display of brochures describing the aims and purposes of the AAMA, its educational opportunities and certification program.

Industrial Medical Association

Chicago

This exhibit portrays the activities of the Industrial Medical Association, including its various services to industry and the community.

Children's Specialized Hospital

Westfield-Mountainside

The Children's Specialized Hospital has been serving children since 1891. Logo and photographs of therapy activities will be exhibited.

1970 Annual Meeting

SCIENTIFIC EXHIBITS

Sunday, May 17—10 a.m. to 5 p.m.
Monday, May 18—9 a.m. to 5 p.m.
Tuesday, May 19—9 a.m. to 3 p.m.

Rhinoplasty: Reconstructive and Aesthetic

Robby Meijer, M.D., John C. Walker, Jr., M.D. and Lyndon A. Peer, M.D., Saint Barnabas Medical Center, Livingston

Reconstructive rhinoplasty was done as far back as 2000 years B.C. Several of the ancient methods are still applied in the repair of nasal defects. Aesthetic rhinoplasty is a popular and gratifying procedure, provided the operative plan takes the face in consideration and that the so-called "operative look" result is avoided.

Problems in Rheumatoid Arthritis Requiring Early Surgical Intervention Relating to Stage and Mechanism

Arthur L. Brooks, M.D., American Academy of Orthopedic Surgery; and Vanderbilt University Medical School, Nashville, Tennessee

Discussed here are indications for early surgery in rheumatoid arthritis, as related to stages and mechanisms.

Surgical Management of Complications of Diverticulitis in Patients over 70

David Befeler, M.D., William F. Mitty, Jr., M.D., Carlo Grossi, M.D. and Louis M. Rousselot, M.D., Department of Surgery, St. Vincent's Hospital and Medical Center of New York; and New York University Medical Center, New York

This exhibit presents data on more than 2800 patients with diverticulosis or diverticulitis. Presented here will be indications for surgery, advantages of the one stage and three stage resection, mortality and morbidity rates, and the results of treatment.

Carcinoma of the Colon

Maurice J. Elovitz, M.D., Sidney Girsh, M.D., Joseph A. Linsk, M.D., Joseph G. Stella, M.D. and Josiah C. McCracken, Jr., M.D., Atlantic City Hospital

This exhibit is designed to show conditions leading to the presence of, or associated with the presence of, carcinoma of the colon. The exhibit includes three dimensional views as well as sigmoidoscopic appearance and color slides of lesions. Methods of treatment, both surgical and medical will be demonstrated as well as diagnostic methodology. Carcinoma of the colon is the leading cause of death among the carcinomas in the United States today. An in-depth attempt will be made to familiarize the physician with the scope of this lesion.

Cervical Discography, Myelography, and Anterior Interbody Fusion

Marvin Chirls, M.D., East Orange

Offered here is an exhibit which shows 250 discograms, myelograms, and anterior interbody fusions with a description of the methods and results.

Heart Screening Survey in Newark

New Jersey Regional Medical Program, East Orange

In the summer of 1969 the New Jersey Regional Medical Program set out to identify the incidence of heart disease and evaluate existing medical services for heart patients in the Model Cities area of Newark. The screening technic is here described and results are reported.

Psychosis and Art

Martin H. Weinberg, M.D., Trenton State Hospital

Shown here are art objects (paintings, sculptures, and so forth) by the patients with comments on their meanings and dynamics. These works were made and exhibited at the Trenton State Hospital.

Today's Problems of Diuretic Therapy

Arthur Bernstein, M.D. and Melvin Odze, M.D., Newark Beth Israel Medical Center

Diuretics are among the most commonly used therapeutic agents. The development of newer diuretics having special areas of utility and unique effects on electrolytes increases the complexity of management. This exhibit will present the mechanisms of action, the signs and symptoms and the management of problems such as potassium depletion, secondary hyperaldosteronism, dilutional hyponatremia and congestive heart failure with rising blood urea nitrogen. The problems of water and electrolyte depletion requiring better understanding and increased management considerations by the physician will be reviewed.

The Patent Umbilical Vein in Portal Hypertension

Albert R. Burchell, M.D., William F. Panke, M.D. and Louis M. Rousselot, M.D., St. Vincent's Hospital and Medical Center, New York

The umbilical vein is spontaneously patent in 9 per cent of portal hypertensive patients. Three functional roles are possible: (1) hepatofugal collateral, (2) bridging collateral, and (3) post shunt accessory outflow tract. Its presence decisively effects the hemodynamics of various types of shunts influencing the degree of protection from ascites.

Endometrial Responses to Various Oral Contraceptives in Family Planning

Maxwell Roland, M.D., Lawrence J. Caruso, M. D. and David Leisten, New York Polyclinic Medical School and Hospital, New York

This exhibit has a twofold purpose: (1) to explain the essential mechanism of reproduction and modus operandi of oral contraceptives, and, (2) to demonstrate the variable endometrial morphologic responses to five commonly used oral contraceptives.

Four endometrial biopsies taken at five cycle-day intervals are compared with the normal untreated endometrium. Also shown is a color motion picture film of culdoscopic or laparoscopic views of the pelvic organs as they appear during treatment with oral contraceptives.

Breakthrough bleeding or secondary amenorrhea in the course of oral contraceptive treatment can be minimized when the patient's pretreatment history is coupled with a study of the morphologic changes of the endometrium at various stages of the cycle.

Basic and Other Biomedical Research at the Institute for Medical Research

Lewis L. Coriell, M.D., Director, Camden

The purpose of this exhibit is to acquaint Society members with the work of the Institute for Medical Research in Camden. Photographs will show cancer and other research.

Bladder Decompensation in Cancer, Cardiac Disease and Stroke

William M. Drake, Jr., M.D., The Cooper Hospital, Camden

Seven charts are shown which outline the etiology, diagnosis, management, and complications of bladder decompensation. Also described is a means of determining the presence of re-compensation and proper follow-up.

Identification of the Hearing Impaired Child

Myron J. Shapiro, M.D., Mark Levey, M.D., Bonnie L. Werner, M.A. and Carole L. Mayer, M.A., Irvington

The purpose of this exhibit is to stress the importance of the early identification of hearing loss and to discuss various technics of testing infants and children. Also presented is an explanation of how hearing handicapped children can be helped. The exhibit will show various testing devices and modalities through pictures, tape recordings, and demonstration of instrumentation.

Computer-Van

Academy of Medicine of New Jersey, Bloomfield; and New Jersey Chapter, American Cancer Society, Newark

This mobile unit provides computerized medical education to physicians and dentists.

Studies in Infant Feeding: Incidence of Colic and Gastrointestinal Disturbances

Lawrence Breslow, M.D., Lutheran General Hospital, Chicago

Disturbances of the gastrointestinal tract (especially colic) are frequently attributable to fat or carbohydrate content of formulas. Here presented is a double-blind crossover study among 127 infants, comparing a standard evaporated milk-carbohydrate formula with a low casein, lower protein diet.

Microcirculation of the Bulbar Conjunctiva

Stanley C. Leonberg, Jr., M.D. and Frank A. Elliott, M.D., The Pennsylvania Hospital, Philadelphia

This exhibit will acquaint physicians with certain facts regarding the human conjunctival microvasculature; particularly in relation to arteriosclerotic cerebrovascular disease. Color photographs of the conjunctival microvasculature have been enlarged into display transparencies. Each is illuminated from behind the exhibit. These are arranged in sections depicting different groups of patients. A descriptive legend accompanies each.

Computer Aided Medical Diagnosis for the Physician

Sidney Auerbach, M.D., Kathleen G. Auerbach, M.D. and Anthony R. Dillworth, Florham Park

Computer aided medical diagnoses is a method which permits the rapid diagnosis of disease. It combines the large memory, speed, and accuracy of the computer with the skill, perceptive ability, and clinical judgment of the physician. The exhibit shows the system in action, and will allow interested doctors to participate in computer aided diagnostic medicine. An important new tool has thus been added to the medical armamentarium.

Granulomas in Bone Marrow Aspirates

Bong Hak Hyun, M.D., Young Ho Park, M.D., Francis Varga, M.D. and Minerva Blank, Ph.D., Muhlenberg Hospital, Plainfield

Fifty-three (4 per cent) of 1300 bone marrow aspirates in which both smears and sections are available disclosed various forms of granulomata. These include 22 "lipid" granulomata, 9 sarcoidosis, 3 Hodgkin's disease, 3 tuberculosis, 2 infectious mononucleosis, 2 typhoid fever, and 12 non-specific tumors. The latter were associated with fever of unknown origin in four and with varieties of clinical conditions in one each. Routine use of histologic sections is stressed as an important means of recognizing bone marrow granulomas, the identification of which is a valuable adjunct in the total evaluation of the bone marrow aspirate. Varieties of granulomata will be demonstrated by transparencies of photomicrographs.

Pesticide Study

Donald Kwalick, M.D., New Jersey State Department of Health, Trenton

Information is presented about the activities of the study; the laboratory services available, free of charge, when pesticide intoxications are suspected; the results of clinical research on persons occupationally exposed to pesticides; and accepted methods of diagnosis and treatment of pesticide poisoning.

Mental Retardation

MSNJ's Committee on Mental Retardation, State Mental Retardation Planning Board and the New Jersey Association for Retarded Children, Trenton

Offered here is a technical and clinical approach to mental retardation. Amniocentesis at 16 to 18 weeks is possible to determine if the baby is involved in chromosomal or inborn errors in metabolism. Informational material is shown to educate the medical community about the sources of aid in handling the mentally retarded.

Dyslexia—The Ophthalmologist Looks at Reading Disorders

MSNJ's Committee on the Conservation of Vision, Hearing and Speech and the New Jersey Academy of Ophthalmology and Otolaryngology

Here is a compact presentation of various causes of reading disabilities, demonstrating the need for a multi-disciplinary approach to reading disorders.

The Pedicle Flap in Restoration of Structure and Function

S. Donald Malton, M.D., Morristown

Here is an exhibit which will demonstrate the use of a pedicle flap to restore structure and function in defects resulting from trauma: It is also useful in congenital anomalies, and in defects at time of excisional surgery which can be constructed immediately. Five examples are demonstrated: (1) Primary reconstruction of the pharynx at the time of excision, (2) Closure of an oro-cutaneous fistula of the pharynx, (3) Reconstruction of the penis following post surgical necrosis (post T.U.R.), (4) One stag repair of hypospadias, (5) A neurovascular flap to restore sensation to the thumb.

Angiography in the Community Hospital

Gilbert S. Melnick, M.D., Stephen B. LoCurcio, M.D. and Philip W. Silverberg, M.D., Saint Michael's Medical Center, Newark

This exhibit will demonstrate the latest methods in arteriography, including magnification arteriography and drug-controlled arteriography. Peripheral venography, including fluoroscopic control will be shown. Lymphangiography, including fluoroscopic control and magnification technics will be demonstrated.

Aids for Subnormal Vision

Gerald Fonda, M.D., John E. Kennedy, M.D. and Charles Ball, M.D., Saint Barnabas Medical Center, Livingston

The purpose of this exhibit is to show methods of rehabilitation of the partly sighted for employment and to enable children to obtain an education with students having normal vision.

The Menopausal Patient: A Changing View of the Change of Life

Robert A. Wilson, M.D., Methodist Hospital, Brooklyn; and Wilson Research Foundation, Inc., New York

The rationale of hormone replacement in menopause is presented, with listings of effects attributable to estrogen/progestogen deficiency and photomicrographs of typical pre- and post-menopausal vaginal cytograms. Practical patient-education programs are suggested, utilizing educational materials from the Wilson Research Foundation and the United States Public Health Service.

Management Of Heart Disease In Children

Milton Prystowsky, M.D., Peter Poulos, M.D., Jose Antillon, M.D., Nestow Truccone, M.D., Jerome Mathias, L.X.T., Alice Forster, R.N and Joyce Mokrzyski, M.T., Department of Pediatric Cardiology and Pediatric Cardiovascular Surgery, Children's Hospital, United Hospitals Medical Center; and Department of Pediatrics, New Jersey College of Medicine and Dentistry, Newark

The exhibitors here demonstrate our experience in the evaluation and over-all medical and surgical management of congenital heart disease. Shown is a breakdown in incidence of the various congenital heart malformations; methods of evaluation and treatment; presentation of representative cases; types of complications encountered during cardiac catheterization and cineangiography; post-operative complications; and follow-up results of medical and surgical treatment.

Our experience demonstrates that with an early and aggressive approach in evaluation and therapy (both medical and surgical), especially in the newborn and infant, we have been able to salvage lives and decrease infant mortality. In many cases, medical therapy is insufficient, and without early surgery, these patients would have died. Furthermore, with open and closed heart surgery we have repaired congenital heart malformations completely while others have been improved by palliative measures either as a final procedure or in preparation for total correction at a future date. Malformations are also presented for which there is, as yet, no known medical or surgical panacea at a certain age.

1,000 Consecutive Cerebral Angiograms Without Sequelae

Robert A. Kuhn, M.D., New Jersey College of Medicine, Newark

Over an interval of half a century, opacification of cervical-cerebral arteries has evolved from injection by surgical exposure to a variety of methods which introduce media from peripheral vessels. All newer technics yield more information at less risk to the patient. The described approach, with no morbidity or mortality, utilizes direct cannulation of the proximal right brachial artery.

Triangular Flap Cutaneous Ureterostomy

Maxwell Malament, M.D. and Stephen H. Corwin, M.D., Veterans Administration Hospital, East Orange

Cutaneous ureterostomy, as a method of urinary diversion, has been in disfavor due to post-operative complications of cutaneous strictures, and distal vascular deficiencies causing necrosis, retraction, and infection. The triangular flap cutaneous ureterostomy is designed to limit skin contraction to a half circle preserving the patency of the ostium. The large area of uretero-cutaneous apposition promotes adequate vascularization. The experience with 21 cases is briefly summarized.

Intensive Design: The Statistical Study Of The Single Case

Jack B. Chassan, Ph.D., Nutley; and George Washington University School of Medicine, Washington, D. C.

Intensive or single case design is an approach to clinical research in which the individual patient rather than groups of patients becomes the focus of inquiry. This exhibit shows how frequent observations of one patient treated with changing medication in a double-blind random fashion can lead to statistically meaningful conclusions. The similarity of the intensive design method of study to clinical practice is pointed out. Graphs developed from an intensive design study will help clarify the explanation of intensive design.

1970 Annual Meeting

TECHNICAL EXHIBITS

Sunday, May 17 — 10:00 a.m. to 5:00 p.m.
Monday and Tuesday, May 18 and 19 — 9:00 a.m. to 5:00 p.m.

In Appreciation

The Medical Society of New Jersey acknowledges with thanks and deep appreciation the generous contribution of ROCHE LABORATORIES. This grant is being used to underwrite, in part, the educational program presented through the scientific sessions.

Abbott Laboratories #18

The Abbott exhibit will feature important pharmaceutical specialties including a widely prescribed non-barbiturate sedative and hypnotic. Also featured is a new hematinic containing folic acid.

Apache Corporation #2

The function of Apache Corporation, through its subsidiary Apache Oil Programs, Inc., is to organize, offer and manage drilling programs for individuals and corporations whose taxable incomes render attractive, and justify, the inherent risk.

Astra Pharmaceutical Products, Inc. #14

Available at the Astra booth will be descriptive literature and information pertaining to Xylocaine® (lidocaine) and Citanest® (prilocaine), local and topical anesthetics, and the intravenous use of Xylocaine® in the treatment of life-threatening cardiac arrhythmias.

B. D. Data Processing Corp. #1

Professional Records

Biocraft Laboratories, Inc. #53

If you wish to save your patient up to 40 per cent, with the finest quality, prescribe: Pen, VK-Wolin. This is made only by Biocraft Labs., Inc., manufacturing specialists in antibiotics.

E. & W. Blanksteen Agency, Inc. #11 and #12

E. & W. Blanksteen have been official insurance brokers for The Medical Society of New Jersey since 1930 for the administration of officially approved plans of disability, major medical and life insurance. Information and literature, as well as personal consultation, are available at this booth.

Joseph A. Britton Agency #10

Information will be available on all forms of MSNJ officially endorsed professional liability insurance.

The Carrier Clinic #19

Information will be available on the facilities of this private psychiatric hospital.

Ciba Pharmaceutical Company #25

Ciba representatives will be on hand to discuss Locorten® (flumethasone pivalate), a new fluorinated corticosteroid specifically designed for the skin.

Ciba Pharmaceutical Company #49

Ciba representatives will be on hand to discuss Esimil® and its benefits.

Coca-Cola USA #48

Ice-cold Coca-Cola will be served.

The Denver Corporation #55

Representatives will offer information on the Imperial American Resources Fund and on Royal Resources Exploration, tax-sheltered investments.

The Dow Chemical Company #36

Diagnostest® instruments and reagents are featured. Here is a diagnostic system developed in conjunction with Bio-Science Laboratories of California for doing blood chemistry tests in the physician's office and stat or stand-by use in hospitals or private laboratories. Accuracy and precision are comparable to reference methods; between-run precision is +6 per cent or better (depending on test).

Thomas A. Edison Industries #34

Thomas A. Edison Industries, Voicewriter Division; 51 Lakeside Avenue, West Orange, New Jersey 07051, will highlight Edison Voicewriter Executive and Secretarial models . . . for individual use by the doctor in his office and at home. Also featured will be Edison Escort, a battery-operated portable dictating instrument. Edison will also show Televoice, the network dictating system for accurate, complete medical records in the hospital.

Encyclopaedia Britannica, Inc. #32

Encyclopaedia Britannica, Great Books of the Western World, Britannica Junior, and other related materials will be displayed.

Gibraltar Security Company #22

Specialists in tax-exempt municipal bonds.

Hoechst Pharmaceutical Company #31

Information will be available on Lasix® (furosemide), Surfak®, Doxidan®, Festal®, and Festalan®.

Knoll Pharmaceutical Company #30

Featured Knoll products will be: Akineton® for Parkinson's disease and drug-induced parkinsonism; Dilaudid®, the analgesic for acute and chronic pain; Quadrinal®, Verequad® and Theokin® Elixir for bronchiospasm and wheezing associated with bronchial asthma, chronic bronchitis and pulmonary emphysema.

Lakeside Laboratories, Inc. #5

Our representatives will have information on Cantils®, Imferon®, Norpramin®, Mercuhydrin®, Metahydrin®, and Metatensin®.

Lederle Laboratories #29

Summary not received

David and Charles Levinson #23

Here is the Medcolator, an electrical muscle stimulater for the relief of musclar pain, sprains, dislocations and other trauma of the muscle and skeletal system. Featured, too, will be the Medco-Sonlator Twin. This is a diagnostic and therapeutic instrument, combining synchronized pulsed ultra sound with Medcolator current in continuous, pulse, surge and reciprocal settings.

The Medcotherm is an electronic instrument designed for simultaneous application of controlled moist infrared heat and electrical stimulation. Also shown is the Achilleometer. This is an instant Achilles Reflex test for testing thyroid function. It offers direct reading on an expanded scale, and it is transistorized and battery operated.

Eli Lilly and Company #20

You are cordially invited to visit the Eli Lilly exhibit and talk with our sales representatives about our pharmaceuticals.

Mead Johnson Laboratories #35

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information.

To make your visit productive, specially trained representatives will be on duty to tell you about Vasodilan-20®, ProSobee®, and Natalins Rx®.

Medical-Surgical Plan of New Jersey #17

Do you have any questions on Blue Shield policies, procedures, or payments? Do you know all about the Blue Shield Prevailing Fee Program that pays usual, customary, and reasonable fees? Have you signed up to participate in it? If not, why not do so at the booth. Representatives of Physician Relations and Medical Advisory Staffs will be on hand to answer your questions and help with your problems.

Medichek, Inc. #43

Medichek is a new dimension in health care. It is a multi-phasic health screening center that uses automated, computer-based equipment and paramedical personnel to collect biological data for your evaluation. It is not a substitute for the traditional physical examination. It is a new entity in the complex of health services. Medichek provides you with the interpretations of a cardiologist, radiologist, ophthalmologist and pathologist for some tests.

Multiphasic health screening is accepted by the AMA, the American College of Radiology, the American Society of Internal Medicine and the College of American Pathologists.

Merck Sharp & Dohme #28

The Merck Sharp & Dohme exhibit has been designed to offer a contribution to your therapeutic armamentarium. Technically trained personnel are available to discuss the scope and variety of services offered to physicians.

Metropolitan Pathology Laboratory, Inc. #38

Physician controlled and operated, our laboratory was established to provide the practicing physician with a private laboratory that maintains standards and quality control presently available only in leading medical centers.

Prominent consultants in academic medicine work actively along with our directors, all of whom hold doctorate degrees, to assure that all diagnostic services performed continue to meet the physicians' demands for quality laboratory service.

Visit the Exhibits

National Clinical Services Labs., Inc. #21

Featured here is a full service automated clinical laboratory with a daily pick up and delivery service covering the entire state of New Jersey.

New Jersey Bell Telephone Company #39 and #40

Telephone equipment and services will be available at the Bell booth.

Olshin's Hospital Supply #6

Olshin's Hospital Supply is a full line medical service company serving doctors, hospitals and industry in the New Jersey area. At this meeting, we will be displaying some of the most recent developments in the medical electronics field featuring the Ames/BMI Blood Analyzer.

Ortho Pharmaceutical Corporation #51

Ortho is proud to present the most complete line of medically accepted products for control of conception and the treatment of vaginitis.

Parke, Davis & Company #15

Parke-Davis is proud of more than a century of service to the medical profession. Our representatives consider it a pleasure to contribute to the success of your meeting. They will be present to discuss the quality products from Parke-Davis, and welcome your comments or inquiry.

Physiodata, Inc. #3 and #4

Diagnostic X-ray Services.

Prudential Drilling Funds, Inc. #41

Prudential Drilling Funds, Inc. provides an investment vehicle, for the high income individual, for investing his tax dollars and an opportunity to create new wealth with his tax savings.

Prudential Insurance Company of America Coffee Lounge

Presenting the Medicare picture as Part B Carrier for the State of New Jersey, and Intermediary for 35 Hospitals, 35 Home Health Agencies and 70 Extended Care Facilities. Representatives will be available to answer your questions and otherwise assist you with Medicare matters.

A. H. Robins Company #33

You are cordially invited to visit the A. H. Robins display and meet our representatives who will welcome the opportunity to discuss products of interest with you. Our most recent new product release is Dimacol™ (pseudoephedrine, phenira-mine, dextromethorphan and glyceryl guaiacolate).

William H. Rorer, Inc. #52

William H. Rorer, Inc. takes pride in exhibiting its fine pharmaceutical products at this convention. Our representatives will gladly discuss Maalox®, Ascriptin®, Ananase®, Quaalude® and our other products with you.

Sandoz Pharmaceuticals #9

Sandoz Pharmaceuticals cordially invites you to visit our display at booth #9, where we are featuring Mellaril®, Hydergine®, Sansert®, Cafergot P-B®, Fiorinal® and Bellergal®. And, of course, any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company #26

Saunders will have on display a complete line of their medical books, including many new titles and new editions—such as, Mudd: **Infectious Agents;** DeLand and Wagner: **Nuclear Medicine;** Brewer: **Juvenile Arthritis;** Conn: **1970 Current Therapy;** Bondy: **Duncan's Diseases of Metabolism;** DePalma: **Fractures and Dislocations;** and many others.

G. D. Searle & Co. #7

Featured at the Searle booth will be Ovulen-21®, Ovulen-28®, Enovid®, Aldactazie®, Flagyl®, Lomotil®, Pro-Banthine®.

siGmj Laboratories #13

siGmj Laboratories presents Serpaspan® (reserpine 0.25mg.) in sustained release micro-dialysis cells.

E. R. Squibb & Sons, Inc. #16

Summary not received

Wallace Pharmaceuticals #44

We invite you to visit our booth where our representatives in attendance will be pleased to furnish information regarding Wallace products and your related medical questions to assist you in your practice.

Warner-Chilcott Laboratories #24

Summary not received

Warren-Teed Phamaceuticals Incorporated #50

Summary not received

Winthrop Laboratories #8

Winthrop Laboratories cordially invites you to visit booth #8, where the following products will be featured: Sulfamylon®, brand of mafenide (as acetate), Talwin Oral®, brand of pentazocaine (as hydrochloride), and Isuprel Mistometer®, brand of isoproterenol.

VISIT THE EXHIBITS
A THREE-WAY TREAT

One of the colorful aspects of our convention is the interesting array of exhiibts. This year, as usual, we have three classes—

Informational — Scientific — Technical

The exhibits help to defray the cost of your Annual Meeting. Take time to visit each booth. There is a wealth of new information available. Representatives will be present to answer your questions.

43rd ANNUAL MEETING

Woman's Auxiliary to The Medical Society of New Jersey

Saturday through Tuesday
May 16-19, 1970

Chalfonte-Haddon Hall
Atlantic City

Schedule of Events

Saturday, May 16, 1970

1:00 p.m. to 4:30 p.m.—Registration for Art Show
(Lobby floor, Haddon Hall)

*1:00 p.m.—Golden Merit Award Ceremony
(Rutland Room, First floor, Haddon Hall)

2:30 p.m.—Auxiliary President's Report to MSNJ House of Delegates
(Windsor Room, Haddon Hall)

Sunday, May 17, 1970

9:30 a.m. to 4:30 p.m.—Registration
(Lobby floor, Haddon Hall)
Tickets for Tea and Fashion Show

10:00 a.m. to 4:30 p.m.—Sale of Tickets
(Lobby floor, Haddon Hall) for President's Luncheon—Monday
(Pennsylvania Room, Haddon Hall)
All doctors' wives invited

10:00 a.m.—Art Exhibit
—County Press and Publicity Books Exhibit
—County Activities Pictorial Display
(Lobby floor, Haddon Hall)

10:00 a.m.—Pre-convention Board Meeting
(Navajo Room, 15th floor, Haddon Hall)

12:00 noon—Fellowettes' Luncheon
(Blue Room, Office floor, Chalfonte)

2:30 p.m.—Tea and Fashion Show
(Vernon Room, Haddon Hall)
All doctors' wives and guests invited

*6:00 p.m.—Reception for President-elect Satulsky
(Pennsylvania Room, Haddon Hall)
Admission by badge

*8:00 p.m.—Reception and Buffet Dinner Honoring Technical Exhibitors
Tickets at MSNJ Registration Desk

Monday, May 18, 1970

8:15 a.m. to 9:00 a.m.—Continental Breakfast
(Hallway, 13th floor, Haddon Hall)

8:15 a.m. to 4:30 p.m.—Registration
(Lobby floor, Haddon Hall)

9:00 a.m. to 12 noon—Tickets on sale
(Lobby floor, Haddon Hall) for President's Luncheon—Monday
(Pennsylvania Room, Haddon Hall)

9:00 a.m. to 12 noon—General Session
(West Room, 13th floor, Haddon Hall)

9:00 a.m. to 4:30 p.m.—Sale of Dinner-Dance tickets at MSNJ Registration Desk

12:30 p.m.—Annual President's Luncheon
(Pennsylvania Room, Haddon Hall)
All doctors' wives invited

*7:00 p.m.—Dinner-Dance
(Pennsylvania Room, Haddon Hall)

Tuesday, May 19, 1970

8:00 a.m.—Breakfast for new county presidents
(Mandarin Room, 13th floor, Haddon Hall)

9:00 a.m. to 10:00 a.m.—Continental Breakfast
(Hallway, Tower floor, Haddon Hall)

9:00 a.m. to 12:00 noon—Registration
(Lobby floor, Haddon Hall)

10:00 a.m.—Post-convention Board Meeting
(West Room, 13th floor, Haddon Hall)

Convention Committee

Chairman—Mrs. Donald McLean
Co-Chairman—Mrs. Charles Gandek

*MSNJ events to which the Auxiliary Members are cordially invited.

ROOM RESERVATIONS

Complete and mail this form for your room reservation

204th ANNUAL MEETING—THE MEDICAL SOCIETY OF NEW JERSEY
May 16-19, 1970

Reservation Desk, Chalfonte-Haddon Hall, Atlantic City, New Jersey

Please Reserve the Following Accommodations—This Reservation Will Be Acknowledged

If room is not available at rate requested, please check here

authorizing us to make reservation at next available rate. ☐

No. of Rooms	HADDON HALL All Rooms Air Conditioned	Single, Bath, 1 Person	Twin Bedroom, Bath 2 Persons	CHALFONTE All Rooms Air Conditioned	Single, Bath 1 Person	Twin Bedroom, Bath 2 Persons
	Without Ocean View	☐14 ☐17 ☐20	*☐18 ☐21 ☐23		☐12 ☐15 ☐17	☐17 ☐19
	Side Ocean View	☐24 ☐26	☐26 ☐28 ☐30		☐20	☐23 ☐26
	Ocean Front	☐34	☐34 ☐36		☐24 ☐26	☐26 ☐28 ☐31
	Double & Parlor		☐48 ☐58 ☐60			
	Double & Parlor Ocean Front		☐75			☐66

EACH ADDITIONAL PERSON IN DOUBLE ROOM $5.00 EUROPEAN PLAN *Roomettes

MODIFIED AMERICAN PLAN (BREAKFAST & DINNER) ADD $8.00 PER DAY, PER PERSON ☐

I will share a room with .....

Day and date of arrival .....Departure .....

Name .....

Address .....

PLEASE PRINT Plus 5% City Tax

NOTE: As check-out hour is 3:00 p.m., rooms may not be ready earlier.

COMMITTEE ON ANNUAL MEETING

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Vice-Chairman, Plainfield

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JEROME G. KAUFMAN, M.D., Maplewood

PETER H. MARVEL, M.D., Northfield

ROBERT E. VERDON, M.D., Cliffside Park

CHARLES L. CUNNIFF, M.D., Ex-Officio, Jersey City

MRS. MARION R. WALTON,
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ROBERT E. VERDON, M.D., Chairman
Cliffside Park
CHAIRMEN AND SECRETARIES
of Scientific Sections

Special Article

The Government And The Risk Factor In Pharmaceuticals

The following is abstracted from a talk by John J. Powers, Jr., on February 28, 1970, before the Graduate School of Business at Harvard University. Mr Powers is the President of Charles Pfizer and Company.

The major issue for the 1970s between government and the pharmaceutical industry will revolve about the ability of government to cope with complex scientific judgments in a manner to benefit the public. This will be a major problem for all science-based industry —for all scientists. The issue arises from the fact that in recent years we have been concentrating in this country increasingly on the *risk element* in the benefit-to-risk ratio that is inherent in all technologic innovations. At its extreme it is a dangerous and crippling posture to assume.

It is easy to ridicule this tendency toward overemphasis on risk rather than a balanced judgment on benefit to risk. One could imagine a great story breaking in 1910 to the effect that airplanes crash and when they do they quite often kill people. An ensuing debate could well have led to a law, or regulation or a policy that we should only make uncrashable airplanes and we would have had no airplane industry. Of course, the subject deserves more than ridicule, for it is far more serious than this suggests.

This *emphasis on risk* for many is a reaction against the swift pace of change which is such a disturbing element in our society. We have had a lot of technologic innovation and it is no longer looked upon with awe and beautiful wonderment, but increasingly with fear and concern. Or it may be even simpler than that. We have built an expanded range of alternatives into our society. Things are so good we can now for the first time in history try to have it both ways—the benefit without the risk, and in this view there may be simple miscalculation. But if so, it may well be tragic for this is an untenable extreme.

The heart of the matter for the pharmaceutical industry is the process whereby new drugs (or new uses for old drugs) are reviewed by the Food and Drug Administration and decisions made whether or not, and under what conditions, they should be marketed. The benefit-to-risk ratio is here presented in a very direct fashion. It must be weighed with respect to every new drug. No drug or other substance ingested in a human being, even in normally accepted foods, is without its toxic level. In the pharmaceutical industry we match the useful level against the toxic level to determine whether the range is wide enough to permit the use of the drug. But, perhaps we forget that others may think in terms of the simplistic approach which suggests that the ideal drug may be efficacious but without *any* toxic effect. While for all practical purposes this is impossible, some are coming dangerously close to such an assumption.

The handling of the benefit-to-risk ratio with respect to drugs is the key issue in the Food and Drug Administration's relationship to industry and to society in its review and approval of new drug applications. It is here that the government through FDA exerts its most powerful influence on progress, or the lack of it, which has an important impact on health care and on the cost of health care. It is also here that FDA makes one of its most important decisions relating to consumer protection. Hence, there is a powerful interplay of two forces in the decision process—progress and risk.

One of the most meaningful insights into FDA's record on new drug decision making was made public by Congressman Rogers in September 1969. Congressman Rogers examined the actual records of time-in-process for all pending new drug applications and discovered that no less than thirty new drug applications have been pending with FDA for

periods of 3 to 6 years. This time lag is on top of the 6 or more years the industry scientists worked with the drug before concluding its safety and efficacy had been demonstrated. What is the reason for the long protracted periods of time in FDA hands especially when it is required by the statute to act within six months? FDA has asserted at times that the root difficulty is inadequacy of the scientific studies proffered by industry in support of their new drugs. This is occasionally true. But it is not an adequate explanation of the delay phenomenon. In most cases, certainly in recent years, our new drugs have been approved on the basis of the scientific data originally supplied. But the applications regularly require far more than the six months of review time stipulated by the statute. This fact might seem to lay the problem at the door of FDA's scientists and physicians. Former Commissioner Herbert Ley has made some very critical comments about the quality of his former associates. But this explanation, plausible in part, is also insufficient to explain fully the long delays. I think that the FDA has largely failed to appreciate its responsibilities for fostering technological progress.

FDA for all practical purposes probably sees itself almost solely as a policeman and hardly at all as an integral part of a system whose output is new drugs and therapeutic advances. This tendency has its roots in the statutes themselves which over the years have spoken predominantly of the FDA mandate to guard and protect. It is reinforced by the incessant pressure from FDA critics whose interest seems to lie in fostering public safety as they see it. If FDA perceives its mandate solely in these terms, its policies and behavior would predictably be of the sort that tend to delimit existing drugs, and to delay the approval of new ones.

Consider the policy question FDA must pose for itself regarding the criteria for judging the safety and efficacy of a new drug. Suppose the regulator asks himself: Is this new drug application complete and perfect in all parts and in every detail? Is there anything whatsoever that could be done to further test the asserted safety and claims for efficacy of the drug? If those are the questions, the answer is likely to be quite different than that to the question: Does this new drug application contain scientific information sufficient to permit a fair-minded and prudent judgment that the drug has its claimed therapeutic values and that these are not outweighed by its side effects or toxicity? The latter is a far more difficult decision. It calls for a greater exercise of responsibility and entails a greater risk of being criticized for occasionally being wrong. An error in underestimating the risk of a new drug is much more likely to become public and clearly evident than an error in delaying, limiting or even suppressing a new drug, though the latter may be the greater harm to society.

Now, for the third time in recent years, the government has recognized that it has problems in its Food and Drug Administration and has changed the commissioner and, presumably, is starting over again. As it attempts to assess the future, it surely must be looking at the possible reasons for prior failures. First, it may be considering what I would call the Ley theory, i.e., FDA people are inadequate. I suggest this is not the heart of the problem, not only because there are many fine dedicated people in FDA, but also because, to the extent the charge is true, it is caused largely by other considerations which I shall mention.

Second is the mismanagement theory, which suggests that this large bureau of government with its variety of responsibilities and massive amount of paper has been inefficiently managed which, incidentally, might have been predicted because its managers simply did not have the type of expertise necessary to the enormous tasks. I think there is something to this theory and I know that the new commissioner, Dr. Edwards, has a background of some years in the management consulting firm of Booz, Allen and Hamilton. This is progress, but how much progress depends, I suggest, on the extent to which recognition is given to the third and, I believe, most fundamental consideration. This is the theory

of the confusing mission of the Food and Drug Administration.

The mission of FDA in relation to technologic innovation is to aid progress and avoid undue risk. There is nothing fixed or quantified about these two vital effects of innovation. They bear shifting values for each situation that arises. They are often difficult to evaluate. They require the highest exercise of judgment in an objective atmosphere. And the evaluator must, in the end, command public confidence, or an already jittery citizenry will be panicked by a succession of cyclamate, pill, and other headlines which may eventually create the greatest deterrent to progress in the quality of life since man invented war.

But this mission of FDA is distorted by the statute under which it operates, the long history of the agency primarily as a policeman and the insistent public criticism which stresses the errors in underestimating risk. These pressures have created a bias which FDA itself has tried to right by seeking to have some difficult scientific evaluations made by prestigious outside and presumably unassailable scientific groups such as the National Research Council. So far, in all but one case, this seems to have held off the public critics, but it is beginning to cause concern among some scientists who challenge some of the methods of the prestigious group as well as some of the conclusions. Their insulation from the public critics may well be temporary, since most of their first conclusions were weighted, fairly heavily on the side of avoiding risk. Wait till they come out for progress! Perhaps the recent pill publicity is an example of the latter.

So the problem seems to be this. First, that it may be difficult to have one agency of government perform the dual roles of enforcer and judge. This needs careful study in itself but one is always uneasy to see these two roles combined in one man or one body. Second, the judge, the evaluator of the benefit-to-risk ratio, must not be pressed by the statute under which his function is established nor by extreme public pressure to give undue emphasis to either the benefit or the risk. It is difficult enough as it is for him to achieve a fair balance.

The FDA has a new commissioner and I would guess that some changes are going to be made. Recently he made a speech to his own staff expressing his philosophy on a variety of subjects and clearly recognized the need for balance in the benefit-to-risk ratio evaluation process. Perhaps my own great concern with respect to this subject, however, led me to be sensitive to the fact that he seemed to use many more words like risk and safety and protection than benefit and progress. I also found puzzling what role he could have intended for what he described as a consumer advisory group to participate in these difficult evaluations.

Meanwhile, may I suggest without elaboration on this occasion, that its instincts were right in reaching toward outside expert groups for help. This may well be a partial solution for FDA for both problems just mentioned. Indeed, I suggest FDA consider encouraging the participation of expert groups from its neighbors in HEW, patterned on the fruitful collaboration that has been quietly going on for some years between industry and the early clinical drug evaluations unit of the National Mental Health Institute!

Secondly, I would urge that FDA policy makers carefully re-examine the criteria for decision making, perhaps calling for guidance upon some of those who have been intensively studying the overall problems of the health system. The criteria for weighing the benefit side of the equation are particularly critical. Anyone can see the virtues of a lifesaving drug. But what about a drug that merely facilitates patient care, thus sparing the time of scarce and increasingly expensive health care personnel? Or a drug that minimizes need for hospitalization? And what about prophylactic drugs where the benefit to the individual patient is probabilistic, but the potential saving to society could be great?

Drugs have a high cost-effectiveness ratio, compared to almost all other modes of patient care.

The type of solution which refers these difficult questions of evaluation to a prestigious body of experts (somewhat removed from the daily strife of the enforcer) is not intended to insulate these questions from any public airing. In the first place, it wouldn't work. Secondly, it is not our way in this country. One might be tempted to get these questions completely away from public opinion if they were solely questions of science But they are not. There are often economic and social values present in the equation and, expert or not, the public is entitled to weigh them when it feels the need to do so. This risks enticing the demagogue into the arena with all kinds of weird possibilities. But, we have very little choice. Frequently people take needed actions only after they have been strongly prodded to do so. Perhaps public controversy is sometimes needed to get results. But the prime purpose of public controversy should be to correct a malfunctioning of the regular system. And when we do have these cathartic public airings they can be helpful only if they push in the direction of a decision or simply point to the need for decision without trying to decide some very complicated questions by a kind of public opinion poll. Professor Brezina pictured the ideal situation as a cycle where the question was taken from the malfunctioning expert usually by a crusading public critic and thus put to the public, thence to the governmental policy maker and finally returned to the expert, presumably for final decision and action. My concern is that in the instant replay kind of communication of the present day, complex, socio-scientific issues may be taken irrevocably out of the hands of those most capable of deciding them and that determinations will then be made which are erroneous and ultimately harmful to large segments or all of society.

As increased participation in the evaluation of the benefit-to-risk ratio of technologic innovation in other industries and other segments of our society takes place it should not begin in an atmosphere heavily weighted toward avoidance of risk. Rather the aim from the outset should be to seek a fair balance between progress and risk. And if there must be an enforcer, consider carefully whether he alone should also be the evaluator of the benefit-to-risk ratio. Our future as a nation is at stake here. Being the most affluent nation we are also the super consumerists, those most concerned about risk, those most ready to slow down progress to avoid risk. The implications of this in a competitive world are clear. Some difficult choices lie ahead.

Res-Q-Aire And Clar Aire Called Dangerous

In a letter to the Editor of JAMA (Vol. 210, No. 7), Dr. Joel J. Nobel of the Emergency Care Research Institute, called attention to the widespread distribution of two dangerous emergency respiration support units— *Res-Q-Aire* and *Clar Aire*. He urged all physicians and health organizations to destroy all of the devices in their possession.

A comparative evaluation of ten manually powered emergency ventilation devices was conducted by the Institute with support from HSMHA. The findings showed that *Res-Q-Aire* and *Clar Aire* could not fulfill their assumed and advertised functions. When the Institute's test results were published, *Clar Aire* was voluntarily withdrawn from the market by its manufacturer, the Clar Aire Corporation. *Res-Q-Aire,* however, despite seizure of shipments by the Food and Drug Administration in many cities, is still being marketed by Res-Q-Aire, Inc., and other distributors.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

February 22, 1970

A regular meeting of the Board of Trustees was held on February 22, 1970 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Utilization Review in Extended Care Facilities . . . Agreed to participate in a discussion group (New Jersey Hospital Association, New Jersey Nursing Home Association, Medicare Intermediaries, and MSNJ) to explore the possibility of a demonstration project in New Jersey concerning utilization review procedures in extended care facilities.

AMA Congress on Socio-Economics of Health Care . . . Authorized John J. Bedrick, M.D. to attend (with expenses paid) the National Congress on Socio-Economics of Health Care, March 20 and 21 in Chicago, and the conference (to be held just prior to the Congress) concerning the "physician assistant" and reated new health occupations, sponsored by the AMA Council on Health Manpower and the Department of Health Manpower.

Council on Legislation . . . Approved the report of the February 5, 1970 meeting of the Council on Legislation, including the following recommended official position of MSNJ on bills of medical import:

(All measures thus marked (*) are identical with bills of last year—or preceding years—whose official positions were the same.)

*S-4 —To prohibit littering of waterways and adjacent shores and beaches and to regulate marine toilets. *APPROVED*

S-11 —To provide for a new system of work permits for minors.
A-109 —(Companion measure to S-12) *APPROVED*

S-12 —To provide for a system of identification cards and health certificates to minors over 12 years of age for use in establishing eligibility for acceptance of gainful employment. (Companion measure to S-11 and A-109) *APPROVED*

*S-19 —To require medical service corporations to pay the Commissioner of Banking and Insurance a fee of $0.02 per subscriber, member or employee covered under contracts. (Companion measure to S-20) *NO ACTION*

*S-20 —To require hospital service corporations to pay the Commissioner of Banking and Insurance a fee of $0.02 per subscriber, member or employer covered under contracts. (Companion measure to S-19) *NO ACTION*

S-27 —To repeal R.S. 2A:134-4 concerning polluting of waters used for ice harvesting. *APPROVED*

*S-102 —To authorize the Trustees of the New Jersey College of Medicine and Dentistry to acquire for their use the Jersey City Medical Center. *NO ACTION*

*S-104 —To provide penalties for first, second and third offenses of violations of the narcotics drug act. *APPROVED*

S-130 —To authorize the Department of Health to regulate the collection and disposal of solid waste. *NO ACTION*

S-163 —To authorize freeholders to close and abolish a county tuberculosis hospital upon determination that continued operation of the hospital is no longer necessary and to provide for public hearing on such resolution. *APPROVED.*

S-181 —To provide that all plans and specifications for construction or alteration of public buildings shall provide facilities for the physically handicapped and to provide for promulgation of guidelines, from time to time, by the State Board of Architects under standards of the American Standards Association, Inc. (Companion measure to S-182) *APPROVED*

S-182 —To require boards of education to provide facilities for the physically handicapped in contracts for construction and alteration of any public buildings guided by standards promulgated by the American Standards Association, Inc. (Companion measure to S-181) *APPROVED*

*S-185 —To provide that any person who advertises, sells or offers any person any compound intended for household use which contains poisonous ingredients and does not label such package clearly is a disorderly person. *APPROVED*

S-191 —To require every applicant for a motor vehicle driver's license upon first applying and every six years thereafter to submit to and pass a hearing and eye examination as shall be prescribed by the Director of Motor

Vehicle. *DISAPPROVED,* although the Society approves the objective of this legislation, it disapproves this measure because of the impracticality of its implementation.

*S-194 —To provide for the licensing and registration of electrologists by the Board of Medical Examiners. *APPROVED*

*S-204 —To repeal the tax on gross receipts of unincorporated businesses. *APPROVED*

S-214 —Requires all State buildings to be provided with facilities for the physically handicapped. *APPROVED*

*S-216 —To provide for civil commitment of drug addicts. *APPROVED*

*S-221 —Prescribes the penalties for a person who sells, gives, administers, or dispenses any narcotic drug other than a medicine preparation. *APPROVED*

*S-223 —To require every district and regional board of education to appoint an advisory committee on narcotics for each of the high schools in a school district, to make studies and advise what measures should be taken to eliminate narcotics from such schools. *APPROVED*

*S-224 —To provide that no hospital or medical service corporation or insurance company shall be entitled to be subrogated to any claim of an insured as against any third party other than the employer of the insured or the employer's carrier or any hospital or physician's lien except payments made under the Workmen's Compensation Law. *DISAPPROVED,* in support of the position of Medical-Surgical Plan of New Jersey and Hospital Service Plan of New Jersey.

*S-226 —To provide for public representation on all professional boards. *ACTIVE OPPOSITION,* because professionally unqualified lay members would encumber the boards, with no appreciable advantage to the public.

*S-230 —To authorize the Board of Medical Examiners to permit municipal hospital employees who hold M.D. or D. O. degrees to practice in the hospital without a license. *DISAPPROVED,* because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in an approved training program.

*S-239 —To remove restrictions against the practice of medicine by persons in the employ of a municipal hospital who hold M.D. or D.O. degrees, and where a physician is duly licensed in any foreign country where requirements for licensing are not substantially lower than New Jersey and while teaching and not in private practice. *DISAPPROVED,* because MSNJ feels that is is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in an approved training program.

*S-240 —To restrict the availability of a patient's medical record for public use except by his consent or upon court order. *APPROVED*

*S-241 —To authorize the issuance of limited licenses to practice medicine and limited licenses as assistants in medicine. *DISAPPROVED,* as undesirable and unnecessary because interns and residents are presently not required to hold licenses as physicians and surgeons to serve in hospitals in New Jersey. No licenses should be granted to other than demonstrably qualified persons who have met the requirements of the Medical Practice Act.

*S-242 —To provide for appointment of two licensed practical nurses to the New Jersey Board of Nursing. *APPROVED*

*S-250 —To provide for the establishment of air pollution control commissions in the counties. *DISAPPROVED,* because there is no evidence that at the present time the control that is now exercised by the Department of Health is not satisfactory and that the personnel who would control these committees would be as well informed in the control of air pollution as the Department of Health. Moreover, the prevailing unified control would be jeopardized.

*S-258 —To provide for the confidentiality of information and data secured by and in possession of hospital or extended care facility utilization review committees. (Our bill) *ACTIVE SUPPORT*

*S-259 —To provide that medical records or photographic reproductions shall be retained by a hospital for seven years following the most recent discharge of a patient or until the confined persons reach age 23, whichever is later; to require retention of a discharge summary sheet for 20 years and x-ray films for five years. *APPROVED*

*S-269 —To permit the Board of Medical Examiners to grant a license for practice of medicine and surgery without further examination where an applicant shows he has been examined and licensed in a foreign country. *ACTIVE OPPOSITION,* because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes or to those of other states whose licensees New Jersey accepts on a basis of reciprocity.

*S-270 —To provide that any applicant for a license to practice medicine and surgery who, in addition to other required proofs necessary to be admitted to examination, shows he has engaged in the practice for 10 years and has reached a position of eminence in his profession shall be granted a license without further examination upon payment of the required fee. *DISAPPROVED,* because it would abrogate the present discretionary powers of the Board to act on the basis of objective evidence and would impose an obligation to make subjective judgments as

to what constitutes "proof," "reputable practice," and "conceded eminence and authority in his profession."

S-293 —To provide for representation on the Board of Trustees of the Hospital Plan of New Jersey of an equal number of subscribers, physicians and public members qualified by background to act in the broad public interest. *APPROVED*

S-330 —To provide for regulation and licensing of medical care facilities and to establish a Division of Health Facilities, Service and Planning in the Department of Health. *APPROVED*

*S-362 —To define, under the Hazardous Substances Labeling and Sales Act, the term "label" as applied to an unpackaged article; the term "misbranded package" to include a child's toy and to provide a definition for "banned hazardous substance." *APPROVED*

*S-373 —To authorize the Commissioner of Health to prohibit, restrict or condition, permanently or for a specified time, any activity contributing to air pollution; to prohibit, permanently, the construction or operation of an industrial process if its contribution to air pollution would constitute an unreasonable risk and to provide for public hearing after public notice upon the proposal to exercise such power. *APPROVED*

S-374 —To authorize a governing body to prescribe penalties for violation of air pollution control ordinances but not in excess of those prescribed in Chapter 212, Laws of 1954, Section 19. *APPROVED*

*S-377 —To establish a Noise Control Act; to empower the Commissioner of Health to promulgate codes, rules and regulations for the control of noise. *APPROVED*

*S-384 —To provide for issuance of certificates for the operation of air pollution equipment or control apparatus in dwellings where such can be operated without violating any pertinent codes or regulations and if such equipment incorporates the latest advances in control technology. *APPROVED*

*S-386 —To authorize the Clean Air Council to establish an ad hoc joint technical committee of seven members with power to promulgate rules and regulations. *DISAPPROVED,* because there is no evidence at the present time that the control now exercised by the Department of Health is not satisfactory and that the personnel of this proposed ad hoc committee would be as well informed in the control of air pollution as is the Department of Health.

*S-388 —To exempt from the restrictive provisions of the N.J. Industrial Home Work Law those persons homebound because of advanced age, physical or mental disability, injury or illness; to provide for medical certification of ability; to establish that the N.J. Rehabilitation Commission, N.J. Commission for the Blind or other agency recommend employment; to authorize the Commissioner of Labor and Industry to promulgate rules and regulations and other amendments. *APPROVED*

S-392 —To provide that the New Jersey Agricultural Experiment Station shall institute research and investigation necessary to establish biology, breeding habits and methods of control of bloodsucking and pest insects which are a health menace. *APPROVED*

S-404 —Provides that a hospital service contract to furnish services shall be for a period of one month and automatically renewed each month unless either party gives a 30-day written notice of termination. (Companion measure to S-409). *APPROVED*

*S-405 —To permit hospital service corporations to adjust premium rates based on experience rating, past or contemplated; to provide that no form of experience rating may be used until the formula has been filed with and approved by the Commission of Banking and Insurance and to require the experience rated group to be assessed a reasonable community charge. *APPROVED*

S-406 —To permit a hospital service corporation to include in its subscription contracts a provision for a lien by way of subrogation on proceeds of any payment in discharge, release, settlement, awards, etc., which the injured subscriber or dependents may have or shall assert against a third party for damages on account of injury. (Companion measure to S-408). *APPROVED*

S-407 —To permit a hospital service corporation to provide for health care services or supplies other than the services of persons licensed to practice medicine or surgery. *APPROVED*

S-408 —To authorize any hospital to enforce a lien to the full extent authorized by law notwithstanding that all or part of its charges for treatment, care and maintenance of an injured has been or will be paid by a nonprofit hospital corporation. (Companion measure to S-406) *APPROVED*

S-409 —To provide that every individual medical medical service contract shall provide for the payment of medical services for a period of one month from date of issue of the subscription certificate and any such contract shall be renewed automatically from month to month unless one month's prior notice is given; to provide that no contract shall be terminated in the absence of fraud or misrepresentation. (Companion measure to S-404) *APPROVED*

S-410 —To permit a medical service corporation to adjust premium rates based on experience rating, past or contemplated; to provide that no form of experience rating may be used until the formula has been filed with and approved by the Commissioner of Banking and Insurance and to require the experience rated group to be assessed a reasonable community charge. *APPROVED*

S-411 —To permit a medical service corporation to include in its subscription contracts a provision for a lien by way of subrogation on proceeds of any payment in discharge, re-

lease, settlement, awards, etc., which the injured subscriber or dependents may have or shall assert against a third party for damages on account of injury. *APPROVED*

S-412 —To provide that any physician shall be entitled to enforce a lien filed by him to the full extent authorized by law notwithstanding that all or part of his charges for treatment, care and maintenance of an injured has been or will be paid by a non-profit medical service corporation. *ACTIVE SUPPORT*

S-422 —To permit a medical student to complete formal studies in the basic sciences and diagnostic medicine in three years and to require such student to serve a full year of intern training in a hospital of a medical college or one affiliated or associated with such medical college *ACTION DEFERRED* until a committee of The Medical Society of New Jersey, appointed by the Board of Trustees, obtains more information on this measure and reports its findings to the Council on Legislation

(*Note:* Subsequently, the Board appointed James A. Rogers, M.D., in consultation with the Executive Director to study this bill and report their findings to the Council on Legislation.)

*S-436 —To provide for continuation of facilities to educate handicapped children through the summer months; to define "atypical pupils" to include those classified as handicapped and include pupils of ages 3 through 20 years. *APPROVED*

*S-463 —To provide for reimbursement for licensed chiropractors' services under any group accident, group health and group accident and health policy or contract. (See S-464) *ACTIVE OPPOSITION*

(*Note:* The position of the 1968 bill identical to S-463 of this year was one of "disapproved". It was the unanimous decision of the Council to change this position to "active opposition" in conjunction with S-464, S-465 and S-466 of this year for the reasons stated under S-464.)

*S-464 —To provide that licensed chiropractors shall have the same privileges and benefits as licensed physicians and surgeons under the act governing medical service corporations. *ACTIVE OPPOSITION,* because the services which chiropractors are licensed to provide are not among the services covered by medical service corporations. They are not licensed or recognized as physicians or surgeons and are not qualified—or licensed—to supply medical and/or surgical services for injuries and/or disease conditions.

*S-465 —To provide for reimbursement for licensed chiropractors' services under accident and sickness insurance policies. (See S-464) *ACTIVE OPPOSITION*

(*Note:* The position of the 1968 bill identical to S-465 of this year was one of "disapproved". It was the unanimous decision of the Council to change this position to "active opposition" in conjunction with S-463, S-464 and S-466 of this year for those reasons stated under S-464.)

*S-466 —To provide that the services of a chiropractor shall be considered medical or surgical services under the Workmen's Compensation Act, any health and accident, disability or other insurance policy or under any labor management trustee, union welfare, employee benefit or any private insurance or welfare plans. (See S-464) *ACTIVE OPPOSITION*

S-475 —To provide that no person shall sell any glue containing a solvent releasing toxic vapors or fumes which does not include an additive as required by the Commissioner of Health. *APPROVED*

SJR-5 —To establish a commission to study and evalate the effects of repeal of the Unincorporated Business Tax, Chapter 137, P.L. 1966. *APPROVED*

SJR-6 —To create a commission to study and evaluate the effectiveness of existing laws, rules and regulations relating to the practice of all branches of the healing arts dealing with any part of the mind or body of human beings. *APPROVED*

SJR-14—To extend the date for submission of the report of the Professional Board Study Commssion to the Governor and the Legislature. *APPROVED*

*SR-1 —To create the "Senate Special Committee on the Training of General Practitioners of Medicine and Dentistry" to inquire into what steps the State medical and dental colleges have taken to comply with legislation to prepare students for general practice in these professions. *APPROVED*

*S-385 —To define "area" in the Air Pollution Emergency Control Act to mean only that portion or portions of the State described in the Governor's air pollution emergency declaration. *APPROVED*

A-6 —To provide that any person who discards an intact television tube in a place accessible to children shall be a disorderly person. *APPROVED*

*A-22 —To direct the Commission of Institutions and Agencies with the advice and assistance of the Narcotics Advisory Council to establish a program for the treatment and rehabilitation of drug addicts who are inmates of correctional institutions and to establish guidelines for use by freeholders in preparing similar programs for inmates of county jails, workhouses or penitentiaries. *NO ACTION*

*A-27 —To provide for the mandatory civil commitment of drug addicts and to establish a procedure therefor. *APPROVED*

*A-42 —To provide that alcohol in excess of 0.05% but less than 0.10% in a motor vehicle operator's blood shall not give rise to a presumption that his driving ability was or was not impaired by consumption of alcohol. *APPROVED*

*A-43 —To authorize a governing body to prescribe penalties for violation of air pollution control ordinances but not in excess of those prescribed in Chapter 212, Laws of 1954, Section 19. *APPROVED*

*A-44 —To authorize establishment of regional air pollution control districts. *APPROVED*

A-47 —To create a Division of Environment Protection in the Department of Conservation and Economic Development. *NO ACTION*

A-53 —To require persons seeking to influence legislation to identify legislation and report disbursements therewith, to file reports in such detail as the Secretary of State may prescribe, to require affidavits where no allocation of activities is possible and to prohibit employment for compensation contingent upon passage or defeat of any legislation. *NO ACTION*

*A-76 —To provide that the term "depressant or stimulant drug" shall include any hallucinogenic drug; to prohibit possession of such drugs by unauthorized persons. *APPROVED*

*A-86 —To provide that the Director of Motor Vehicles shall license an applicant upon payment of the lawful fee and receipt of a certicate issued by a teacher of an approved driver education course attesting to the applicant's ability as a driver. *DISAPPROVED*

A-109 —To provide for a new system of work permits
S-11 —for minors. *APPROVED*

A-110 —To provide for a system of identification cards and health certificates to minors over 12 years of age for use in establishing eligibility for acceptance of gainful employment. *APPROVED*

*A-111 —To provide that any incorporated nonprofit association, organization, league, society or other group created to protect dumb animals shall have the same rights, powers and privileges vested in the Society for the Prevention of Cruelty to Animals. *DISAPPROVED,* because there is no evidence that existing statutes protecting dumb animals from cruelty are now being flagrantly violated or that the SPCA has failed—or is failing—to perform its responsibilities in enforcing those statutes.

*A-127 —To create an Advisory Committee on Solid Waste Collection and Disposal in the Department of Health which shall review and evaluate the effectiveness, efficiency and economy of techniques of collection and disposal of solid waste and recommend programs of research and development, including pilot projects, demonstrations and experiments for the purpose of testing and evaluating such techniques in actual working conditions. *APPROVED*

A-128 —To require every applicant for a motor vehicle driver's license, and once every 4 years therafter, to submit and pass an eye examination; to provide for designation of an official optometrist and ophthalmologist from a list of three names to be submitted by the New Jersey Optometric Association and The Medical Society of New Jersey, respectively. *DISAPPROVED,* although the Society approves the objective of this legislation, it disapproves this measure because of the impracticality of its implementation. Moreover, this bill as drawn disregards that fully licensed physicians and surgeons have a legal right to examine eyes and would discriminate against them.

*A-130 —To provide for civil commitment of drug addicts. *APPROVED*

*A-137 —To provide that abuse of a child shall include care and custody of a child by a parent or other person convicted of any crime or offense relating to use or sale of narcotic drugs and to provide a procedure for persons originating child abuse proceedings. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because there is no dependable logical basis for the presumption that a parent or guardian convicted of "any crime or offense relating to the use, possession, sale, transportation or other dealing in or with narcotic drugs" would be per se guilty of child abuse. Furthermore, some of the individuals granted the right to initiate proceedings under this bill do not possess requisite educational and clinical experience to determine that the resulant injury was not accidental.

*A-163 —To empower the Governor to do all necessary things to insure that all State Departments and local political subdivisions secure full benefits available under the National Highway Safety Act and to prepare a comprehensive plan to reduce traffic accidents under the New Jersey Highway Safety Program. *APPROVED*

*A-200 —To provide for licensing, inspection and regulation of medical care facilities, to create a Commission on Hospital Care and Related Services and to provide for enforcement. *NO ACTION*

*A-217 —To require all passenger automobiles to be equipped with ventilating systems while the motor is running, effective July 1, 1971, of a type approved by the Director of Motor Vehicles. *APPROVED*

*A-232 —To include hallucinogenic drugs under the depressant or stimulant drug law; to prescribe penalties on the illegal use of LSD and other hallucinogens. *APPROVED*

*A-233 —To provide that whenever a related individual has reason to believe any person is a narcotics addict such related individual may file a petition with the county clerk requesting such person be admitted to a hospital for treatment of his addiction. *APPROVED*

*A-234 —To include in the definition of optometry one who sells, at retail, to the general public spectacles or eyeglasses containing other than plano lenses; to provide that nothing in the definition of optometry shall prohibit a duly licensed ophthalmic dispenser from providing eyeglasses as prescribed by an optometrist or physician. *DISAPPROVED,* because the vending of such glasses is not proper or exclusive to the practice of op-

tometry, whose fundamental function (under law) is to examine for defects of vision and to prescribe corrective lens. This legislation would deny to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and is discriminatory.

A-245 —To provide for closing or abolition of any county tuberculosis hospital determined by freeholders as no longer necessary. *APPROVED*

*A-251 —To provide that no hospital emergency receiving room shall be open for treatment unless there is in attendance at least one person on the staff who speaks English and is capable of interpreting same in the language of the licensed medical practitioner in charge of such room. *APPROVED*

*A-261 —To provide for commitment of convicted sex offenders; to provide for physical and mental examinations and special treatment; to provide for payment of maintenance costs by the treated person or his family. *APPROVED*

A-265 —To provide for hospitalization of any person attempting to commit suicide, to authorize apprehension of persons deemed dangerous to themselves and to repeal the statute making the attempt to commit suicide a disorderly persons offense. *APPROVED*

A-309 —To provide that where injury or death is caused by the negligence of a physician, surgeon, nurse, dentist, chiropractor, osteopath or other person rendering service under the Workmen's Compensation Law such person shall be liable at common law for any negligence. *NO ACTION*

*A-319 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-358 —To authorize the Commissioner of Health to prohibit, restrict or condition, permanently or for a specified time, any activity contributing to air pollution; to prohibit, permanently, the construction or operation of an industrial process if its contribution to air pollution would constitute an unreasonable risk and to provide for public hearing after public notice upon the proposal to exercise such power. *APPROVED*

*A-360 —To prohibit thermal discharges from flowing into any waters of this State except under approved conditions. *APPROVED*

*A-367 —To create a Governor-appointed commission known as the Rutgers, South Jersey Medical and Dental College Planning Council, to choose a site for a medical-dental school in South Jersey. *ACTIVE SUPPORT*

*A-368 —To establish a Noise Control Act; to empower the Commissioner of Health to promulgate codes, rules and regulations for the control of noise. *APPROVED*

A-383 —To provide that the course in health in public schools shall include instruction in the study of nutrition and the selection and preparation of food for personal and family consumption. *APPROVED*

*A-405 —To establish a Division of Medical Care Facilities within the Department of Health which shall have comprehensive responsibility for the development and administration of the State policy with respect to hospital and related medical care services in all public and private institutions and to provide that the board of directors of hospital service corporations shall be composed of an equal number of representatives of hospitals, subscribers, and the general public. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because it poses a threat to the free practice of medicine and the continued life of the Medical-Surgical Plan of New Jersey.

*A-415 —To provide that the State Sanitary Code may contain regulation on the collection and disposal of solid waste and to provide that the State Department of Health shall supervise sewage treatment or solid waste collection and disposal facilities. *APPROVED*

A-428 —To require any person applying for a motor vehicle license to accompany his application with a doctor's certificate certifying that he is not an alcoholic. *DISAPPROVED,* because there is no way a physician can certify that an individual is not an alcoholic.

*A-429 —To define a "depressant or stimulant drug" to include any hallucinogenic drug, including d-lysergic acid diethylamide (LSD), n-n-dimethyltryptamine (DMT), psilocybia, mescaline, peyote, bufotenin, epena, parua, ayahuasca, yage, caapi, amaneta, muscaria and other substances and to provide penalties. *APPROVED*

A-448 —To provide that the phrase "substance containing any chemical material having the property of releasing toxic vapors or fumes" shall mean and include but not be limited to any glue, cement, adhesive, paint remover or other chemical compound. *APPROVED*

*A-494 —To require disclosure of generic and brand names on drug compounds and medicines. *APPROVED*

*A-525 —To provide that unauthorized persons who practice medicine or surgery without first having obtained a license are disorderly persons. *DISAPPROVED,* because sanctions of existing law are adequate to protect the public against the unauthorized practice of medicine and surgery or any violation of the Medical Practice Act. Moreover, many of the provisions of present law deal with technicalities the violation of which should not warrant the stigmatization of the of fender as a disorderly person.

*A-555 —To provide for determination of potable water standards by the Department of Health; to provide for hearings prior to adoption of such standards; to prohibit construction of any new water supply system, pumping station or water stoppage facility

until the sanitary engineering features of plans and specifications have been reviewed and to provide for supervision of all water supply systems with respect to quality, protection and maintenance of adequate volume. *APPROVED*

*A-557 —To permit the Department of Health to exempt incinerators which by type and size, in their opinion, should not be subject to the licensing requirements of the solid waste disposal act. *APPROVED*

*A-576 —To provide that the Commissioner of Institutions and Agencies shall not issue a certificate of approval for operation of narcotics treatment centers unless he is satisfied that proper care complying with standards can be performed and to provide that the State Board of Control of the Department of Institutions and Agencies shall adopt, promulgate and enforce such other rules and regulations deemed necessary. *NO ACTION*

. . . Adopted the following recommendation after being informed that some sixty measures have been introduced in the Congress that would provide for the inclusion of chiropractic services under Medicare, (New Jersey Congressmen sponsoring such legislation are: Helstoki (D), Daniels (D), Gallagher (D), Widnall (R), Rodino (D), Sandman (R), Patten (D), Minish (D), Howard (D), and Dwyer (R):

That the publications of "Independent Practitioners Under Medicare," a report to Congress by Wilbur J. Cohen, Secretary of the Department of Health, Education and Welfare, and *At Your Own Risk* by Ralph Lee Smith, an experienced medical journalist, be sent to the aforementioned sponsors.

Committee on Child Health . . . Adopted (as amended by the Board) the following recommendations, as approved by the Council on Public Health:

(1) That The Medical Society of New Jersey cosponsor a statewide Rubella Immunization Program, to be launched by the New Jersey State Department of Health; and that the Society encourage component societies and local organizations to support the program.

(2) That the State Department of Health be requested to provide the necessary vaccine and that the necessary legislative action be taken to empower the purchase of said vaccine for use in cases where individuals are unable to meet the required fee.

(3) That The Medical Society of New Jersey endorse whatever measures are necessary or indicated to make Rubella one of the diseases for which immunization is recommended prior to admission to school, and that the New Jersey State Department of Education be so informed.

Committee on Conservation of Vision, Hearing, and Speech . . . Adopted the following recommendations, as aproved by the Council on Public Health:

(1) That the Eye Health Screening Program be conducted in 1970.

(2) That the Board of Trustees invite the Lions Club of New Jersey to be a cooperating agency for the Eye Health Screening Program.

(3) That the total expenses of exhibit at MSNJ's 1970 Annual Meeting in Atlantic City by the Committee on the Conservation of Vision, Hearing, and Speech, be defrayed by MSNJ.

Committee on Environmental Health . . . Adopted the following recommendations, as approved by the Council on Public Health:

That a letter be sent to the State of New Jersey's Department of Transportation, stating that MSNJ, being cognizant of the extreme health hazards to the populace from automotive emissions, as well as the tensions surrounding driving on today's clogged, accident-prone highways, urges that:

The State Department of Transportation concern itself with exploring ways and means of controlling harmful automotive emissions and developing statewide alternate methods of *emission-free* mass transportation. Also, MSNJ offers its cooperation in such a program and cordially invites a representative of the State Department of Transportation to attend subsequent meetings of the Committee on Environmental Health *(Italic's* indicates amendment by the Board of Trustees.

Salmonellosis . . . Adopted the following recommendation as submitted by the Council on Public Health:

That MSNJ request the State Department of Health to advise the public of the proper method of thawing and cooking frozen foods in view of the hazard of salmonellosis.

Scientific Exhibit Awards . . . Approved the following recommendations (as amended by the Board) of the Committee on Scientific Exhibits:

(1) That the award presentations for the most outstanding scientific exhibits be made at the third session of the House of Delegates on Tuesday, 19 May 1970.

(2) That there be three plaques awarded for presentation to New Jersey exhibitors (first, second, and third place); two plaques awarded for presentation to out-of-state exhibitors (first and second place); and that there also be five Honorable Mention certificates for New Jersey exhibitors, and two Honorable Mention certificates for out-of-state exhibitors.

(3) That if there are exhibits presented by medical students from New Jersey's two medical schools, they each be presented with certificates of merit, plus a check in the amount of $50.

Compensation under Medicaid for Professionally Incorporated Physicians . . . Directed that correspondence from the President of the State Board of Control (Department of Institutions and Agencies), which stated that any resolution or policy position on the part of the Board which directed their fiscal agents to render payments for health services to the individual physician and not to the professional corporation *has been rescinded,* be received and noted. Payment may be made to individuals or to corporations—in the latter case, the claim form must indicate the name of the physician providing the service, or the physician providing the primary service, if more than one physician is involved in treating the patient.

Corneal Tonometric Examinations by optometrists . . . Directed that a letter be addressed to Attorney General Kugler asking him if the opinion issued by Deputy Attorney General Saros that, under the Optometric Act, optometrists have the legal right to use a local anesthetic in performing a corneal tonometric examination, is to be accepted as a formal opinion, and if not, that he issue a formal opinion on this question.

Conference of County Society Presidents . . . Rescheduled the meeting of County Society Presidents and Presidents-Elect with the Board for April 19, 1970. (The meeting scheduled for February 15 was canceled because of unfavorable driving conditions.)

AMA Regional Conference on Health Quackery-Chiropractic . . . Authorized Henry J. Mineur, M.D. (Chairman of MSNJ's Committee on Quackery) to attend (with expenses paid) the AMA Regional Conference on Health Quackery-Chiropractic to be held May 1, 1970 in Boston.

Connecticut Medical Society Annual Meeting . . . Designated Isaac N. Patterson, M.D. of Westville to attend (with expenses paid) the Connecticut Medical Society Annual Meeting in Hartford, Connecticut, May 12 to 14, 1970. (Since the alternate delegate for Dr. Hamilton (deceased) is unable to attend, the Board made the above appointment.)

Major New Roles for Nurses . . . Directed that the Society record itself as strongly questioning the propriety of the AMA Board of Trustees' action in making the following policy decision without first obtaining the concurrence of the AMA House of Delegates: "The Board voted to endorse in principle a sharp increase in the utilization of nurses and other qualified health professionals in medical care, under the direction of physicians, and to direct all appropriate AMA councils and committees to intensify their efforts to achieve this expansion of medical services."

Note: The American Nurses Association has issued a statement in opposition to this action of the AMA: "It is not the prerogative of one profession to speak for another . . . we strongly object to this action by the AMA, that they would attempt to meet the physician shortage by compounding the shortage of nurses."

ENTERTAINMENT

Saturday, May 16 **9 p.m.**

Viking Room, Haddon Hall

Mary Mulholland, Vocalist
(Auxiliary Member from Morris County)

Clement M. Jones, M.D., Magician
(Member from Hudson County)

Passaic County Choral Group
Fritz, F. Aldler, M.D.
Sandor A. Levinsohn, M.D.
Irving R. Haygan, M.D.
Joseph R. Jehl, M.D.
Roger C. Laauwe, M.D.
James A. Rogers, M.D.
Ciro S. Tarta, M.D.



News From NJCMD

The faculty, students, and alumni of NJCMD are proud to participate in the 204th Annual Meeting of The Medical Society of New Jersey. We are delighted with this opportunity to meet our many friends from all over the state and beyond its borders.

We're particularly proud that we have been able to program the Special Session on Drug Abuse to be held Sunday, May 17th. Many physicians, like other parents, businessmen, and citizens, are bewildered by the lightning developments and phenomenal spread of the narcotics problem. We hope this special program will help us all—members, spouses, guests, and faculty—to understand the many phases of the drug problem spreading across the land in cities, suburbs, and rural areas alike.

The new Division of Drug Abuse (see "News From NJCMD", March 1970 issue. Journal, MSNJ), created within the Department of Public Health and Preventive Medicine at NJCMD, is under the direction of Dr. Donald B. Louria, Professor and Chairman of the Department. Dr. Louria, who is recognized as a leading expert on narcotics and their effect on the public health, will be a member of the symposium presented at this special session. Also participating will be Stanley Einstein, Ph.D., Coordinator of the program of Drug Abuse Education at NJCMD, and editor of *International Journal of Addictions.* The Director of the Division of Drug Abuse, Dr. Edward A. Wolfson, will participate in a study of the responsibilities of the medical profession.

Preceding the Drug Abuse Session, Dr. Samuel J. Fortunato will chair the Section on Obstetrics and Gynecology. Dr. Fortunato is Clinical Assistant Professor of Obstetrics and Gynecology. Speakers in this section will include Dr. Harold Kaminetzky, Director of the Department at Martland and Head of Obstetrics and Gynecology at NJCMD, and Dr. James L. Breen, Associate Professor of Obstetrics and Gynecology.

Simultaneously, Dr. Ronnie B. Hanauer will be discussing recent advances in diseases of muscle, and presiding at the Section on Rheumatism. Dr. Hanauer is Clinical Assistant Professor of Medicine at NJCMD.

One of the afternoon sessions will spotlight another side of NJCMD, with a four part Symposium on Medical-Surgical Problems in Cardiovascular Disease. Dr. Allen B. Weisse, Associate Professor of Medicine will conduct the symposium and serve as moderator at the panel discussion which will follow. Also on the Cardiovascular panel will be Dr. Russell W. Brancato, Clinical Professor of Medicine at NJCMD, Dr. Gilbert E. Levinson, Professor of Medicine, Dr. Joseph J. Timmes, Professor of Surgery, and Dr. Victor Parsonnet, Clinical Associate Professor of Surgery and Director of Surgery at Newark Beth Israel Medical Center, an NJCMD affiliate.

Also on Sunday afternoon, Dr. Martin H. Wortzel, Clinical Assistant Professor of Medicine, will co-preside at the session on Dermatology and Metabolism.

NJCMD alumnus Dr. Alan G. Posta will chair the Section on Allergy which will be held Monday. Dr. Posta, who practices in Trenton, is a member of NJCMD's Class of 1960, the first graduating class.

Also on Monday, Dr. Walter Nudelman, Clinical Assistant Professor of Medicine at

NJCMD, will preside over the Section on Chest Diseases. Joining him will be two colleagues, Dr. Benjamin Rush, Professor and Chairman in our Department of Surgery; and Dr. Milton Singer, who is Associate Attending in Medicine at NJCMD's affiliate, Beth Israel. Dr. Philip J. G. Quigley, Clinical Assistant Professor of Pathology, and Dr. Benjamin H. Schatman will preside at the Sections on Clinical Pathology and on Gastroenterology and Proctology. Dr. Schatman is Clinical Assistant Professor of Surgery. One of the speakers will be Dr. Leo H. Spiegel, Clinical Associate Professor of Medicine. A joint session of the Sections on Urology and Radiology will see Dr. Frederick Lerman co-conducting. Dr. Lerman is Clinical Assistant Professor of Surgery. Discussing the field of Chemotherapy will be Dr. Bernard J. Koven, Assistant Professor of Clinical Medicine and Director of our Oncology Division.

Three seminars featuring NJCMD personnel take place Monday afternoon. Dr. Alvin A. Florin will act as moderator at the Symposium on Comprehensive Care of the Stroke Patient. Dr. Florin is Clinical Assistant Professor of Medicine. At the Section on Ophthalmology, Dr. I. Allen Chirls, Clinical Instructor of Surgery, will preside. Dr. Chirls will be joined by two colleagues from NJCMD—speaking on Photocoagulation of Retinal Diseases will be Dr. John C. Leaman, Assistant Professor of Surgery, and speaking on the Natural History of Diabetic Retinopathy will be Dr. Joseph C. Patt, Instructor in the Division of Ophthalmology.

Dr. Stephen R. LoVerme will chair the Section on Plastic and Reconstructive Surgery. Dr. LoVerme is Associate Clinical Professor in the NJCMD Division of Plastic Surgery. Also speaking at this session will be Dr. Jerome Gelb, who is Assistant Clinical Professor of Plastic Surgery.

Monday evening's Dinner-Dance honoring the Medical Society President and Mrs. Nicholas A. Bertha will also show NJCMD ties in evidence. The official welcome will be given by Mrs. Edward O. MacDonald, President of the State Woman's Auxiliary, who will also be awarded the Fellowette's Pin by Dr. Bertha. Mrs. MacDonald can also be claimed by NJCMD as an important asset to *our* auxiliary, and as *the* auxiliary to one of our faculty, Dr. Edward MacDonald, Clinical Instructor in our Surgery Department.

Now, if that's not enough, two important exhibits have been arranged by members of the NJCMD family. The first, "Today's Problems of Diuretic Therapy," will be presented by Dr. Arthur Bernstein, Clinical Assistant Professor of Medicine; and Dr. Melvin Odze, Clinical Instructor of Medicine. Presenting a study of "Angiobiography in the Community Hospital" will be a team of physicians including our Dr. Gilbert S. Melnick, Clinical Assistant Professor of Radiology.

We are proud of the active involvement in New Jersey's medical profession by the members of our family at NJCMD. We know this participation will continue to grow over the years, and we welcome the important opportunities this will give us and our faculty, staff, and alumni to work with the medical profession for the betterment of medical health care in the Garden State.

Visit The Exhibits

Informational

Scientific

Technical

May 17-19 Haddon Hall

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY—Richard Helfant, M.D., Peter Bent Brigham Hospital, Boston, Massachusetts 02115. NYU—Bellevue 1963. Board eligible. Cardiac catherization laboratory in hospital. Available July, 1970.

DERMATOLOGY—Frederic R. Rothman, M.D., 413 College Parkway, Rockville, Maryland 20850. Michigan, 1964. Board certified. Partnership or group. Available July 1970.

David J. Tuckman, M.D., U.S. Darnall Army Hospital, Fort Hood, Texas 76544. Hahnemann, 1964. Board certified. Group, partnership, or solo. Available July 1970.

GENERAL—Richard D. Hasz, M.D., 1535 Sixth Street, Waynesburg, Pennsylvania 15370. University of Buffalo 1963. Board eligible. Solo or partnership. Available August 1970.

Robert J. Ailes, M.D., 72 Van Allen Road, Glen Rock, New Jersey 07452. Western Reserve 1964. Group, hospital, or industrial (part-time only) Available.

INTERNAL MEDICINE—Chaim Charytan, M.D., 109 Eastridge Drive, San Antonio, Texas 78227. Einstein College of Medicine, 1964. Board eligible. Subspecialty, nephrology. Solo, partnership, group, or institution. Available July 1970.

Noel I. Robin, M.D., 19 Lake Shore Court, Brighton, Massachusetts 02135. Downstate Medical Center (NYU), 1965 Board eligible. Subspecialty, endocrinology. Group (teaching hospital and medical school affiliation). Available July 1970.

Barry R. Zitomer, M.D., 14501A DelAmo Street, Santa Ana, California 92705. Pennsylvania 1963. Board eligible. Partnership or group. Available July 1970.

Stephen H. Jacobs, M.D., Quarters 8620, Fort Lewis, Washington 98433. Georgetown 1964. Board eligible. Group or partnership (preferably Bergen County). Available August 1970.

Allen Chinitz, M.D., 650 West 64th Drive, Hialeah, Florida 33012. NYU (Downstate) 1961. Board eligible. Solo, partnership, or group. Available September 1970.

Panagis Kokolis, M.D., 1602-D South 30th Street, Philadelphia, Pennsylvania. University of Athens (Greece) 1957. Board eligible. Group, partnership, or solo. Available.

Allan M. Sulzer, M.D., 1148 Plainfield Road, Cleveland, Ohio 44121. University of Pittsburgh 1964. Board eligible. Partnership. Available December 1970.

NEUROLOGY—Steven L. Eisen, M.D., 165 West End Avenue, New York 10023. Albany 1966. Board eligible. Solo, partnership, or group. Available June 1970.

Harvey H. Kornblit, M.D., 1906 Wyndale, Houston, Texas 77025. Zurich (Switzerland) 1956. Solo, associate (full or part-time), or group. Available.

OBSTETRICS AND GYNECOLOGY—Stan P. Smith, M.D., 3702A Spruce Street, Dover, Delaware 19901. Temple, 1964. Board eligible. Partnership. Available September 1970.

Michael Mandell, M.D., 296 Duncan Court, Loring AFB, Limestone, Maine 04750. Albert Einstein 1963. Board eligible. Group or partnership. Available July 1970.

OTOLARYNGOLOGY—Robert P. Plotkin, M.D., 145 Fourth Avenue, Apt. 4E, New York, New York 10003. Wisconsin, 1962. Board eligible. Associate. Available July 1970.

Phil Brunner, M.D., 5 Clipper Road, Palos Verdes Peninsula, California 90274. NYU (Downstate) 1965. Board eligible. Group. Available August 1970.

James S. Butler, M.D., Bassett Army Hospital (Fairbanks, Alaska), APO Seattle, Washington 98731. George Washington 1963. Board certified. Partnership, group, or solo. Available February 1971.

PATHOLOGY—Frank P. Urso, M.D., 100 Beatty Road, Media, Pennsylvania 19063. University of Miami 1962. Board eligible. Partnership, solo, institution. Available August 1970.

PEDIATRICS—Thavorn Kunakasem, M.D., 208 Highland Road, Cape May Court House, New Jersey 08210. University of Medical Science, Thailand 1957. Board certified. Group or partnership. Available.

Dudley L. King, M.D., 11852 Big Tree Road, East Aurora, New York 14052. NYU at Buffalo 1954. Board certified. Associate or group. Available July 1970.

Howard Singer, M.D., 265 Explorer Street, K.I. Sawyer AFB, Michigan 49843. University of Pittsburgh 1965. Board eligible. Group or partnership. Available October 1970.

PHYSICAL MEDICINE—Peter T. Han, M.D., VA Hospital, Department of PMRS, Brooklyn, New York 11217. Shanghai Tung Teh 1948. Group or hospital. Available January 1970.

RADIOLOGY—Santos F. Delgado, M.D., 2201 Dublin Road, Pulaski, Virginia 24301. Santiago (Spain) 1953. Board certified. Group, partnership, or association. Available spring 1970.

SURGERY—Francisco D. Avellana, M.D., 2670 Montana Avenue, Apt. 8 Cincinnati, Ohio 45211. University of Manila 1959 Board eligible. Group, partnership, or solo. Available July 1970.

Richard H. Unger, M.D., 106th General Hospital, APO San Francisco 96503. Seton Hall 1963. Board eligible. Group, associate, solo. Available August 1970.

Manuel S. Garcia, M.D., 903 Hensley Heights, Man, West Virginia 25635. Santo Tomas (Manila) 1957. Board eligible. Solo or associate. Available.

L. Frank Henry, M.D., 5402 Montgomery Street, Springfield, Virginia 22151. Virginia 1963. Subspecialty, chest and vascular. Available July 1970.

German Gonzalo, M.D., 66 Bellevue Avenue, Upper Montclair, New Jersey 07343. Barcelona University 1962. Board certified. Group or partnership. Available June 1970.

Antero C. Tan, M.D., 9823 Memphis Road, Brooklyn, Ohio 44144. University of Santo Tomas 1961. Board eligible. Partnership or group. Available July 1970.

UROLOGY—Federico P. Lachia, Jr., M.D., 2440 Corning Avenue, Oxon Hill, Maryland 20022. University of Santo Tomas, 1954. Board eligible. Associate, group, or partnership. Available.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during February 1970.

	1970 February	1969 February
Aseptic meningitis	8	9
Primary encephalitis	1	5
Post-infectious encephalitis	0	0
Hepatitis: Total	87	112
Infectious	69	96
Serum	18	16
Malaria		
Military	6	16
Civilian	0	1
Meningococcal meningitis	10	13
Mumps	333	210
German measles	86	79
Measles	212	56
Salmonella	34	44
Shigella	10	23

Fifth Disease

An outbreak of fifth disease (erythema infectiosum) occurred in a Camden County elementary school during early February. Over-all attack rate was 9 per cent among a student body of 730, with a range of 0 to 53 per cent by class. The highest attack rates were observed among fifth and sixth grade classes. No faculty members developed a skin rash. The striking features of the illness were a fiery red facial flush ("slapped cheek" appearance), and a lace-like erythematous rash on extremities and back. The rash was evanescent in nature, with a tendency to fade and then recur. Highly significant was the lack of associated constitutional manifestations such as fever, malaise, respiratory or gastrointestinal symptoms.

Central Nervous System (C.N.S.) Disease of Viral Etiology, 1969

Morbidity from viral C.N.S. disease in New Jersey declined in 1969 compared to 1968. In 1969, there were 235 cases of aseptic meningitis contrasted to 361 cases in 1968. All counties except Warren and Sussex reported cases of aseptic meningitis. Specific viral agents were identified in 38 instances (16 per cent), compared to 46 cases (13 per cent) in which a specific viral agent was documented in 1968. Among the agents implicated, mumps virus accounted for ten cases; coxsackie B4, eight cases; echo 14, five cases, and echo 6, four cases. As expected, peak incidence of illness was observed during the summer months, with 56 per cent of the year's cases occurring during July, August, and September.

Morbidity from encephalitis was reduced from 59 cases in 1968 to 33 last year. No cases of mosquito-borne arbovirus encephalitis were confirmed in 1969, whereas 12 cases of eastern encephalitis had been documented in humans during the late summer and autumn of 1968. Specific viral agents were associated in only two of the 33 cases (6 per cent). One was herpes simplex, and the other poliomyelitis virus. The polio virus was isolated from the stool of an infant who had received trivalent oral polio vaccine shortly before the onset of his illness. The illness was mild, and he recovered without neurologic sequelae.

Seminar on Drug Abuse

Pennsylvania Room

May 17 10 A.M.

ANNOUNCEMENTS

The Vestibular System

The New York Eye and Ear Infirmary will present a new course on the vestibular system in otologic diagnosis. The program is scheduled for May 3, 4, and 5, and the tuition fee is $100. For more information, write to the Graduate Institute, Eye and Ear Infirmary, 310 East 14th Street, New York 10003.

Clinical Application of Basic Sciences

The final series of the Burlington County Memorial Hospital's program on the clinical application of basic sciences will be held on three Thursdays during May. Each lecture begins at 3:30 p.m. and is held in the T. J. Summey Building of the Hospital. The American Academy of General Practice credits 1½ units per session.

May 7 Acute and Chronic Heart Failure

May 14 Surgical Management of Heart Disease and Selection of Patients for Transplants

May 21 Pulmonary Embolic Disease

For information, please write to the Director of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly.

Corrective Nasal Surgery

May 10 through the 13, this year, (before our Annual Meeting starts) there will be offered by the New York Eye and Ear Infirmary a compact, full-time attendance-limited course described as "functional, corrective surgery of the nasal septum and related structures." The $175 tuition fee includes luncheons on these four days. For more details, write to the Graduate Institute, Eye and Ear Infirmary, 310 East 14th Street, New York 10003.

Cancer Seminar In Denver

The highly successful seminar on cancer of the breast (sponsored by the American Cancer Society) will be held this year in Denver. The seminar meets on May 14, 15, and 16 at the Brown Palace Hotel. If you are a member of the House of Delegates of The Medical Society of New Jersey, your place will be in Atlantic City on the 16th. But, if not, you can fly out to Denver and be back in plenty of time for the scientific program of our Annual Meeting on May 17 and 18.

Electroencephalography Award

The American Electroencephalographic Society offers the Hans Berger Award of $300 for a manuscript dealing with electroencephalograpy, either clinical or experimental. Eligibility for the award is limited to individuals at pre-doctoral and early post-doctoral levels. Candidates shall not be more than five years post-doctoral or two years post-residency. Manuscripts should be submitted by June 1, 1970 to: Dr. Reginald G. Bickford, Neurosciences Department, School of Medicine, University of California, La Jolla, California.

Electronic Instrumentation

A unique course in electronic instrumentation in offered at the Brooklyn Polytechnic Institute, July 25 to August 15, 1970. This summer's course will concentrate on instrumentation in research studies. The $550 tuition fee will cover laboratory fees, textbooks, and syllabuses. For more information write to Professor Kenneth Jolls at the Polytechnic Institute, 333 Jay Street, Brooklyn, New York 11201.

Electroencephalography Course

A three day course in clinical electroencephalography will be held beginning September 14 in Washington, D.C. The course is designed to review the principal applications of the EEG to clinical medical practice, and is sponsored by the American Electroencephalographic Society. For further information, write to Dr. Donald W. Klass at the Mayo Clinic in Rochester, Minnesota.

LETTER TO THE JOURNAL

And Next Coffee?

Dear Sir:

In your January issue you say that no single human fatality has ever been reported from coffee.

A somewhat more ominous viewpoint was expressed in a Letter to the Editor of *JAMA* by Doctor John T. Flynn of New York. He points out that tea and coffee are well known to produce minor cardiac arrhythmias, particularly ventricular premature contractions, and speculates that a more serious arrhythmia might develop in patients recovering from myocardial infarctions. His concern over the use of coffee, tea, and cola drinks by such patients appears justified. A lover of coffee myself, I, nevertheless, feel that it is not a "safe, sober, sage, and venerable liquid" for all. Certainly, the patient recovering from a recent myocardial infarction and the patient with an active peptic ulcer may not find comfort in caffeine.

(signed) William F. Westlin, M.D.

Editor's Note: If it isn't cylcamate, it's baby food, or cranberries. Someone is always taking the joy out of life. Apparently Dr. Flynn, in his letter to *JAMA*, did not actually ascribe any fatalities to coffee but he did warn of the possible hazards.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

April

14 **Bergen County Medical Society**

14 **Cumberland County Medical Society**

14 **Academy of Medicine of New Jersey**
Section on Dermatology
Chanticler Restaurant
Millburn
Cryotherapy in Dermatology, 1970

14 **Associated Eye Residencies**
(Newark Eye and Ear Infirmary, Jersey City Medical Center, Martland Medical Center, VA Hospital)
Newark Eye and Ear Infirmary
"Magnetic and Nonmagnetic Foreign Bodies"

15 **Academy of Medicine of New Jersey**
Section on Urology
Marriott Motor Inn
Saddle Brook
Awards Dinner

15 **Academy of Medicine of New Jersey**
Section on Dentistry
Veterans Administration Hospital
East Orange
Symposium: "Preventive Dentistry"

16 **Burlington County Memorial Hospital**
Mount Holly
Fits, Faints, and Funny Turns

16 **Gloucester County Medical Society**

16 **Morris County Medical Society**

16-30 **New Jersey Regional Medical Program**
New Jersey College of Medicine and Dentistry, Academy of Medicine of New Jersey, and The Cooper Hospital
Cooper Hospital, Camden
"Cancer Chemotherapy"

17 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

21 **Warren County Medical Society**

22 **Academy of Medicine of New Jersey, New Jersey Diabetes Association, New Jersey Department of Health**
Clara Maass Hospital
Belleville
Symposium on Diabetes

22 **New Jersey Public Health Association, American Academy of Pediatrics (New Jersey Chapter), MSNJ**
Holiday Inn
New Brunswick
Conference on Comprehensive Child Care

23 **Burlington County Memorial Hospital**
Mount Holly
The Significance of Hypoglycemia

23 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Bloomfield
Interesting X-rays of the Month

30 **Burlington County Memorial Hospital**
Mount Holly
Definition, Etiology, and Classification of Congestive Heart Failure; The Pathology and Dynamics of the Failing Heart

May

1 **Academy of Medicine of New Jersey**
Eye Division
Dyslexia

4 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

5 **Hudson County Medical Society**

6 **New Jersey Heart Association**
Rutgers
New Brunswick
Myocardial Infarction and Drug Therapy

6 **St. Michael's Medical Center**
Newark
Controversies in Management of Heart Problems

6 **St. Barnabas Medical Center**
Livingston
Familia Toxemia

7 **Burlington County Memorial Hospital**
Mount Holly
Evaluation and Medical Management of Acute and Chronic Heart Failure

12 **Associated Eye Residencies**
(Newark Eye and Ear Infirmary, Jersey City Medical Center, Martland Medical Center, VA Hospital
Newark Eye and Ear Infirmary
"Dylexia"

12 **Bergen County Medical Society**

13 **Ocean County Medical Society**

13 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

14 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Heart Disease and Selection of Patients for Heart Transplant

16-19 **The Medical Society of New Jersey**
Chalfonte-Haddon Hall
Atlantic City
Annual Meeting

21 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Management of Pulmonary Embolic Disease

21 **Gloucester County Medical Society**

21 **Morris County Medical Society**

25 **Cape May County Medical Society**

27 **Academy of Medicine of New Jersey**
Mayfair Farms
West Orange
Annual Awards Dinner

27 **Middlesex County Medical Society**

June

3 **New Jersey Gastroenterological Society**
Newark
Annual Meeting

6 **Radiologic Society of New Jersey**
Berkeley-Carteret Hotel
Asbury Park
Semi-annual Meeting

9 **Bergen County Medical Society**

9 **Cumberland County Medical Society**

10 **Middlesex County Medical Society**

10 **Ocean County Medical Society**

10 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

OBITUARIES

Dr. Ned O. Bowman

Born in 1903, Ned O. Bowman, M.D., died at the age of 67 on February 18, 1970. He was a Duke University Medical School graduate (class of 1932). Ten years after graduation he gave up practice temporarily and served in the Navy during World War II. On being demobilized, he returned to Middlesex County and was active in the affairs of that county medical society. He was a general practitioner with special interest in obstetrics.

Dr. Paul R. Long

Death came on February 22, 1970 to Paul R. Lang, M.D., at the age of 60. Dr. Lang was originally a Pennsylvanian and received his M.D. degree at Temple University Medical School in 1936. After general internship in Pittsburgh he decided to give our state a trial and moved to southern New Jersey, starting his practice in Bridgeton. Dr. Lang served the people of Cumberland and surrounding counties for 45 years, doing mostly general surgery, with time out during World War II for service in the Navy. He was active in the development of the Elmer Community Hospital.

Norman J. Quinn

One of Atlantic County's senior practitioners, Norman J. Quinn, M.D., died on January 16, 1970 at the age of 81. Dr. Quinn was a 1913 graduate of the Jefferson Medical College, and during World War II was Captain in the Army Medical Corps. While he did extensive general practice and was much interested in family medicine, he had especial skill in obstetrics, with a tour of duty as chief of obstetrics at Atlantic City Hospital.

Dr. Salvatore Siniscalco

One of Camden County's best known medical practitioners, Salvatore Siniscalco, M.D. died on February 28, 1970, at the age of 74. A few years ago, the Camden County Sons of Italy elected Dr. Siniscalco the "Man of the Year." He received his M.D. degree at the University of Naples in 1921. During the 1940s, he was active in the affairs of our Camden County Medical Society. Dr. Siniscalco served the families of southern New Jersey for almost half a century. He would have been one of the recipients of this year's Golden Merit Awards at the MSNJ 1970 Annual Meeting.

Dr. John B. K. Smith

Less than year after his appointment as medical director of the N.J. State Hospital at Ancora, John B. K. Smith, M.D., died at the age of 62 on February 4, 1970. He was board-certified in psychiatry, and a Fellow of the American Psychiatric Association. Prior to his service at Ancora, Dr. Smith had been medical director of the State Hospital at Farnhurst, Delaware. He was a native of Scotland, and earned his M.D. at Glasgow University in 1931. He was a psychiatric consultant in Britain until 1955, when he came to the United States and served psychiatric institutions in North Carolina. He then came to our State Hospital in Trenton as director of professional education. From 1958 to 1960 he was the director of Alaska's Division of Mental Health, returning to New Jersey in 1960 as Clinical Director of the State Hospital at Marlboro.

Dr. Julius Sobin

It came as a surprise to most of us to learn that Jules Sobin was 82 years old at the time of his death on January 7, 1970. He certainly seemed much younger and more vigorous. Actually, he had, in effect, two medical careers, and he must have been one of the very few board-certified psychiatrists in the United States who was also a Fellow of the American College of Surgeons. He was a 1915 graduate of Columbia University's College of Physicians and Surgeons, and after the 21-month internship, then the rule at the Newark City Hospital, he entered the Army Medical Corps in 1917. He was on active foreign duty throughout World War I and then returned

to Newark where he did general practice with an increasing interest in surgery in general and otology in particular. Indeed, he became sufficiently involved and skilled to earn his F.A.C.S. He then became interested in psychiatry, and for years operated the psychiatric clinic at the Newark City Dispensary—often single-handed. Just as he was perfecting his skills in psychiatry, the United States entered World War II, and he returned to active military service. He soon became a full colonel and a hospital administrator in the Army. Then he returned to civilian life as chief of the acute psychiatric service at Lyons, and later as chief of psychiatric service at the Veterans Administration Regional Office in Newark. In the meantime, he won his American Board Diploma in Neurology and Psychiatry. When the VA opened its East Orange Hospital, Dr. Sobin became director of its large psychiatric service. He served several mental hygiene clinics and was on the Board of Health in East Orange, his adopted home town. He was emeritus attending or consulting psychiatrist at several hospitals in the Essex County area.

Dr. Carmine Vaccaro

January 16, 1970 saw the death of Carmine Vaccaro, M.D., one of Newark's best-known family practitioners. Born in Naples in 1903, he received his M.D. from the University in that city in 1929. He then came to Newark and served the people of that city for 35 years as a general practitioner. He was 67 years old at the time of his death.

BOOK REVIEWS

Manic Depressive Illness. George Winokur, M.D., Paula J. Clayton, M.D., and Theodore Reich, M.D. St. Louis, 1969, Mosby. Pp. 186. (Softback $6.50)

The title, it is noted, is *illness*, not reaction or psychosis. The authors do indeed think of this psychosis as a medical illness, with many pages devoted to genetic and chromosomal factors.

For treatment, the authors give little space to psychotherapeutic technics, but do discuss in some detail electroconvulsive therapy—suggesting it for manic as well as for depressive attacks. They recommend reassurance (explaining to the depressed patient that his doubts about himself have no basis in reality), chloral hydrate to promote sleep, use of monamine oxidase inhibitors and tricyclic iminobenzine derivatives, the tranquilizers, and, for mania, lithium salts. Also included is an analysis of residual sodium and other electrolytic changes, the catecholamine hypothesis, the role of indole-amines in this illness, and some interesting reports of steroid studies. Parts of the text sound like a revisit with Emil Kraepelin, but this is a thoroughly up-to-date book. The authors stress the importance of being sensitive to the suicide dangers among depressed patients, and include a useful interview form for patients.

Abraham Leff, M.D.

Arrows of Mercy. Phillip Smith. Garden City, New York, 1969, Doubleday. Pp. 244. ($5.95)

For a century or more, curare was a kind of pharmacologic curiosity, of historical interest and the source of anecdotes, but little more. Its usefulness in transplant surgery, the development of its alkaloids, and its potency as a muscle relaxant have now quickened interest in curare. In this popularly written story of curare, Mr. Smith presents the colorful background of the drug in the South American jungles, its use as a poison tip for arrows, and the interesting, (and at times, poignantly ironical) account of the Englishmen and North Americans largely responsible for the development and taming of the drug. It is really an absorbing story, told in a fresh and vivid manner. Mr. Smith also takes us on a detour into a popularization of anesthesia and its problems. There is no general-interest book quite like this. Its background information on anesthesiologic problems in general and curare in particular will be of value to most physician readers too.

Henry A. Davidson, M.D.

Adrenergic Neurotransmission. (Ciba Foundation) Edited by G. E. W. Wolstenholme and Maeve O'Connor. Boston, 1969, Little, Brown. Pp. 123. Illustrated. ($4.50)

Here is a well written, concise monograph on a specialized phase of adrenal physiology. It contains informative papers and interesting discussion on catecholamine metabolism, noradrenaline synthesis and release mechanisms. It is however of limited value to the clinician.

Earl Kanter, M.D.

Modern Treatment (Vol. 6, #5): **Treatment of Acute Renal Failure,** John P. Merrill, M.D., Editor; **Treatment of Infectious Forms of Arthritis,** Frank R. Schmid, M.D. and Richard H. Parker, M.D. Pp. 253. ($16 per year by subscription)

This is a collection of essays on two separate topics. The first, an excellent presentation of renal failure, will keep the practicing internist abreast of current knowledge of pathophysiology and treatment of renal failures. The several brief but interesting essays review differential diagnoses, treatment in detail, indications and contra-indications for peritoneal dialysis and hemodialysis with costs and setup of home dialysis programs; and general problems of transplant immunity, as well as the clinical problems of transplant patients. The essays are pithy and concise and are sprinkled with useful nuggets of information. Particularly to be commended is the material on the use of drugs in uremia. This points out the precautions and hazards, both in type and in dosage, of drugs used for relief of specified symptoms of uremia.

The second collection of essays concerns infectious forms of arthritis. This material is extremely detailed and informative, but some of the discussion is repetitive and some of the chapters could well have been condensed.

The entire volume is splendid and would be a helpful addition to every practicing physician's library.

Samuel F. Einhorn, M.D.

Diseases of Metabolism (Vols. I and II), edition 6, Edited by Philip K. Bonday, M.D., Philadelphia, 1969, Saunders. Pp. 1437. Illustrations 594. ($39—single volumes @ $21)

Duncan's handbook on metabolism which has been a standard text for twenty years, and a fixture in many hospitals and internists' libraries, got a new face-lifting. As a matter of fact, it is practically a new book. Its emphasis is on biochemistry and genetics. A reader who is not up-to-date in his literature is overwhelmed with the erudition presented in these two volumes. The contributors are eminently competent and handle their subjects in a very lucid manner.

As in most books with many contrihutors it is sometimes unavoidable that the same points are brought out and discussed by two authors in different chapters. One also has a feeling that occasionally some authors emphasize their pet subjects more in detail and short-change others.

The short chapters on genetics by Weissman and Braverman and on molecular diseases by Koenigsberg are essential for any physician who tries to understand, in depth, any of subjects. The chapters on diabetes by Dr. Bondy and thyroid disorders by Dr. Rawson are masterful in their presentation. Practically all the newest research in those fields is brought out with such ease that only a person well versed in them can appreciate the amount of work required. A few short chapters at the end bring up-to-date the latest biochemical developments in their respective field, since the book went to print.

A textbook of this character has been badly needed in view of the rapid advances in biochemistry. It will provide authoritiative information for anyone using it as a reference or seeking to acquaint himself more thoroughly with the subjects.

Otto Brandman, M.D.

Crisis Fleeting. (Original Reports on Military Medicine in India and Burma). Compiled and Edited by James H. Stone. Office of the Surgeon General, Department of the Army, Washington, D. C., 1969. Pp. 423. Illustrations 16. ($3.75)

The author who served as a military historian in World War II has compiled an interesting and informative account of the most difficult military operation in warfare history: the operations of the India-Burma theatre in 1943-45. Many sources of information such as official reports, correspondence and conversations with key participants provide the material for this book. This volume is timely because its locale and fighting conditions are similar to those of Viet Nam. The technic of air dropping supplies to isolated fighting units was first developed here, and lessons learned there were later applied in the Berlin airlift and now in the Viet Nam War.

Frustrating and disastrous military engagements with excessive casualties were common because of the hostility that developed between the allied commands. Superimposed on this was the high morbidity because of malaria, dysentery and other tropical diseases endemic in a hot, humid, and unfriendly environment.

The reader is impressed with the tolerance of the human body to withstand such frightful physical strains for no longer than a few months. This costly lesson prohably decided the limit to which combat soldiers in Viet Nam were permitted to fight in the jungle before they were replaced by fresh troops. *Crisis Fleeting* is a first hand descriptive account of the most frustrating agonizing struggle of brave men fighting in one of the most hostile areas in the world.

Henry A. Brodkin, M.D.

Current Concepts in Ophthalmology. (Vol. 2). Bernard Becker, M.D. and Ronald M. Burde, M.D. St. Louis, 1969, Mosby. Pp. 267. Illustrated. ($21)

This excellent book includes papers on diverse subjects, most of them by the staff of the Oscar Johnson Institute at the Washington University School of Medicine. The essays are of uniformly good quality and make for much stimulating and thoroughly enjoyable reading.

While some books are obsolete by the time of their publication, the material here is not at all outmoded. This applies well to the discussion of herpes simplex keratitis with its sections on epidemiology, clinical manifestations, laboratory tests and the use of antiviral agents, steroids, debridement, cryotherapy and surgery.

The optics and the methods of contact lens biomicroscopy are well set forth, as is the exposition of vitreous and retinal pathology. A large section is devoted to fluorescein angiography with clear demonstrations of the normal and the abnormal.

The sections on cryosurgery of cataracts, plastic surgery, and thyroid ophthalmopathies, while familiar to most are well-organized and clear. Especially good are chapters on exodeviations—their diagnosis and management—and on amblyopia. The latter, by Cibis, provides substantial food for thought. This is definitely a valuable book for the ophthalmologist to own. It will provide for very pleasant reading of varied subjects that are stimulating and thought provoking.

S. Jerome Greenfield, M.D.



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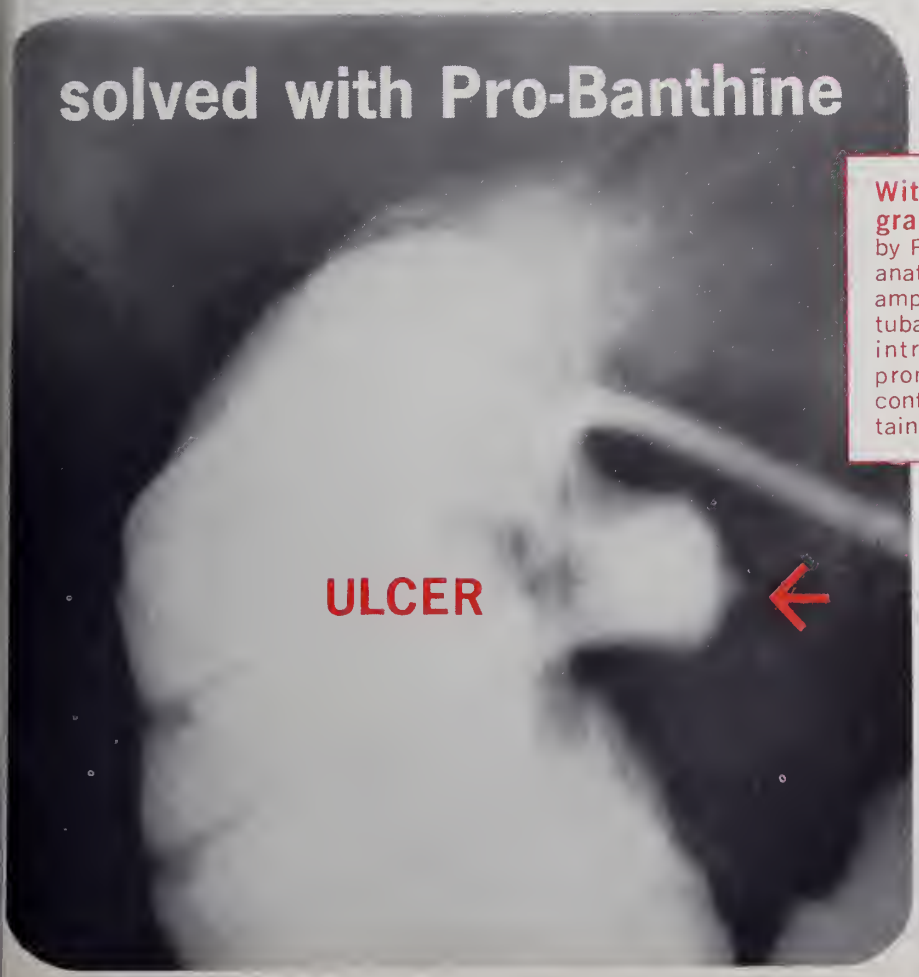
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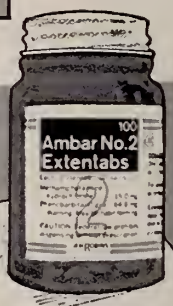


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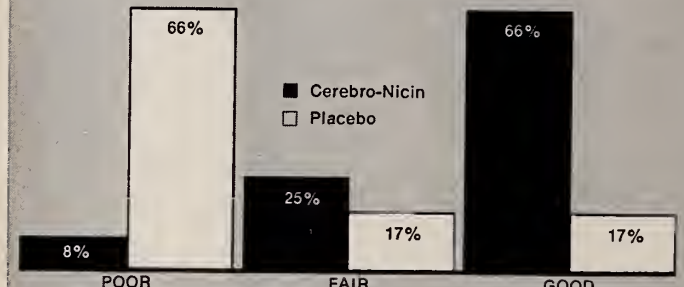
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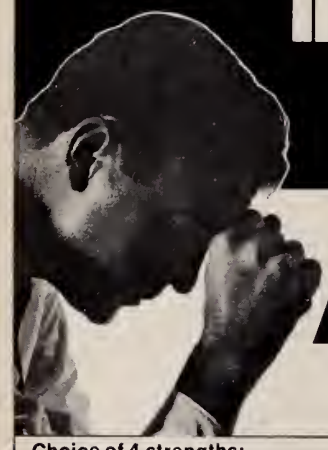
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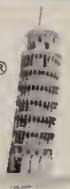
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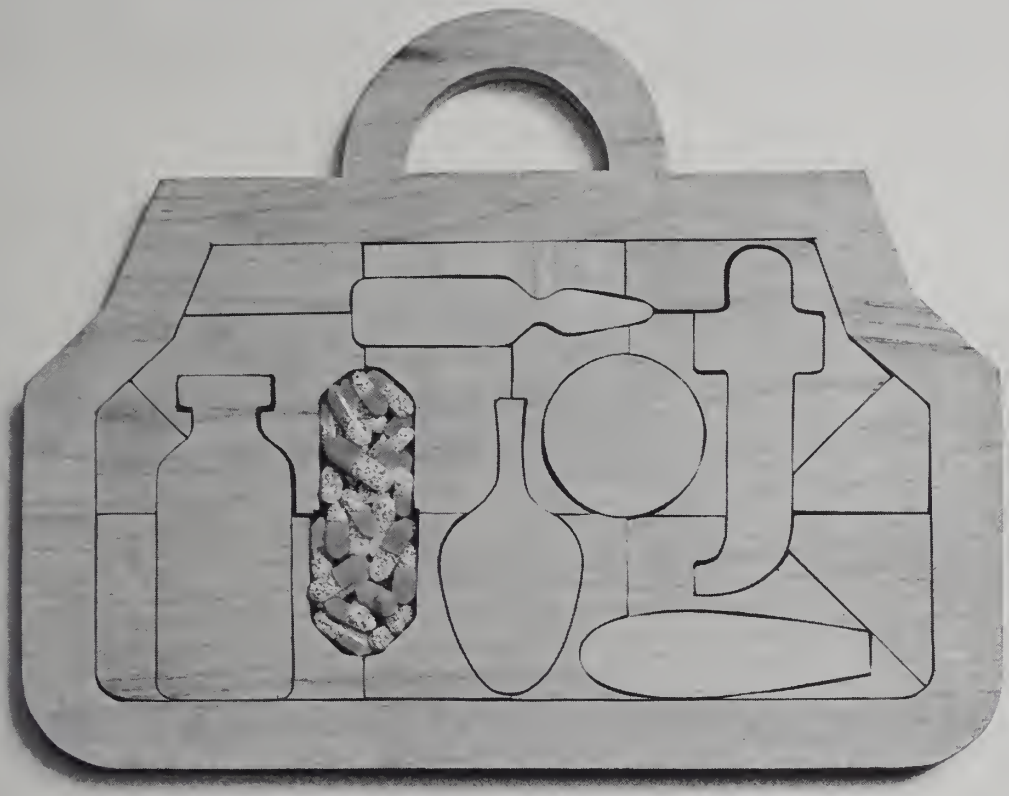
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References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1956. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:87, 1964. 3. Tittel, A. E. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Heilman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Collan, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79 99.

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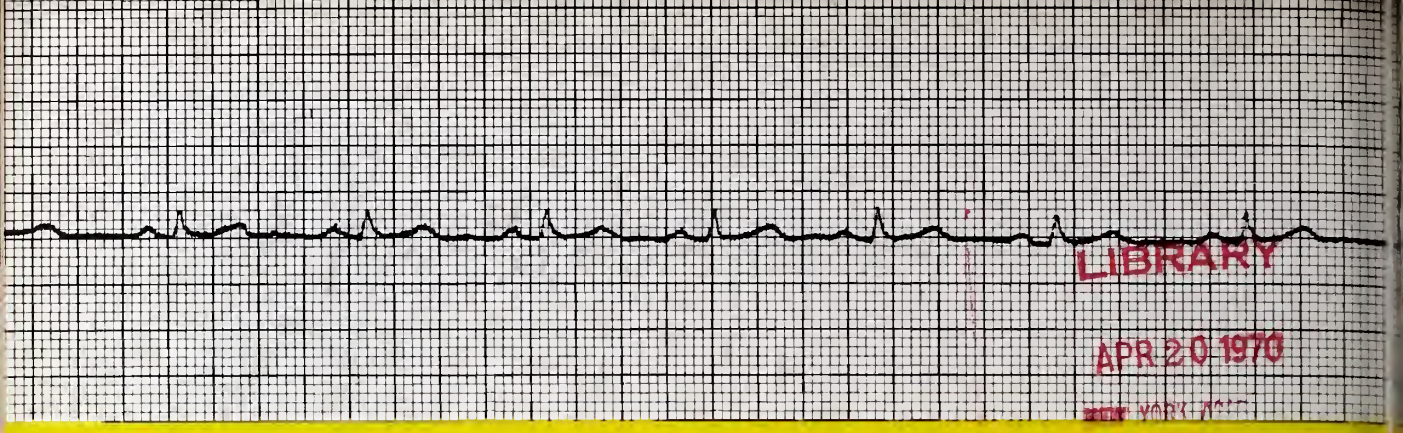
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VOL. 67, NO. 5

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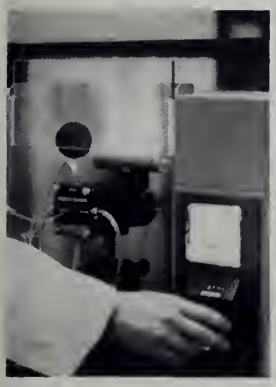
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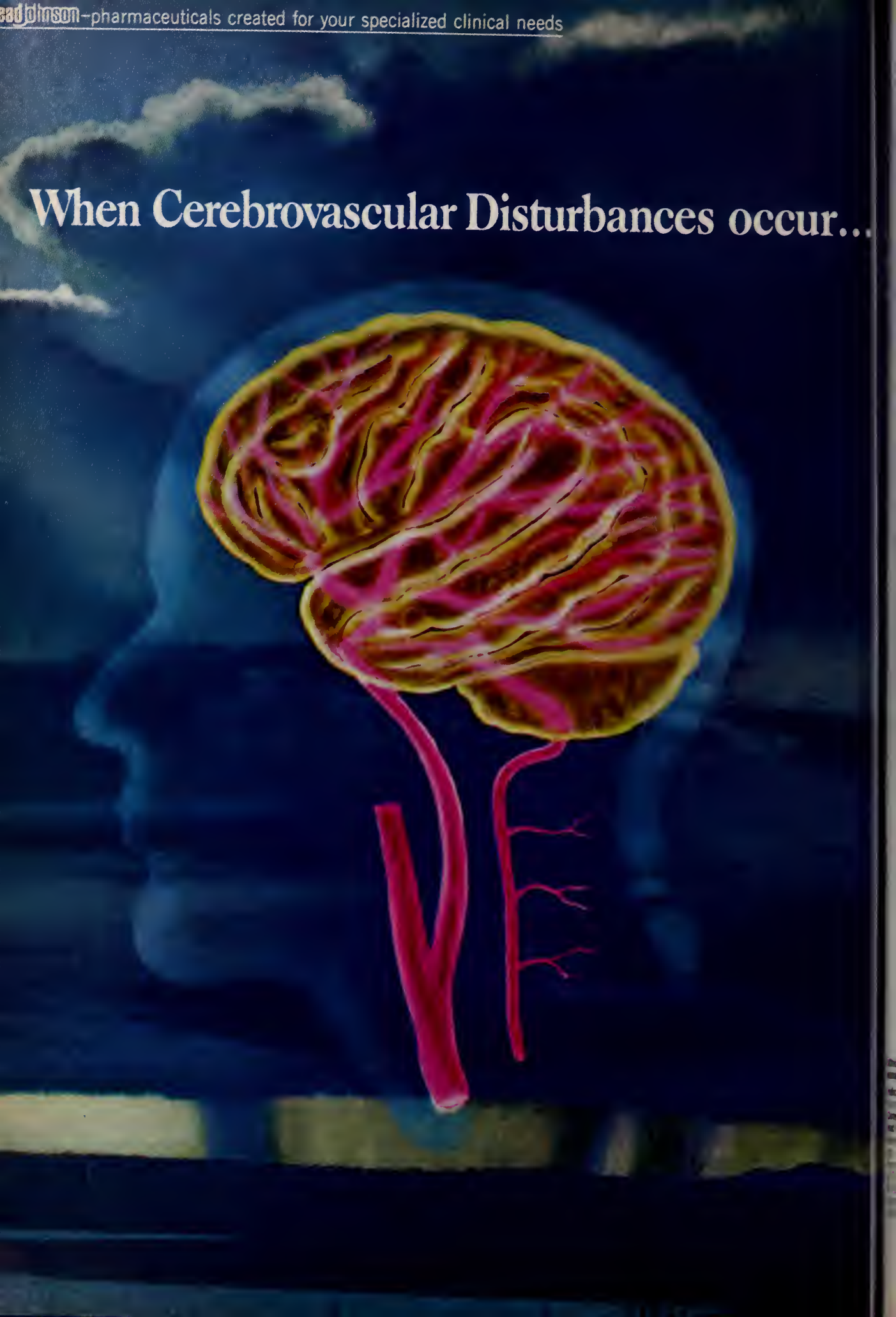
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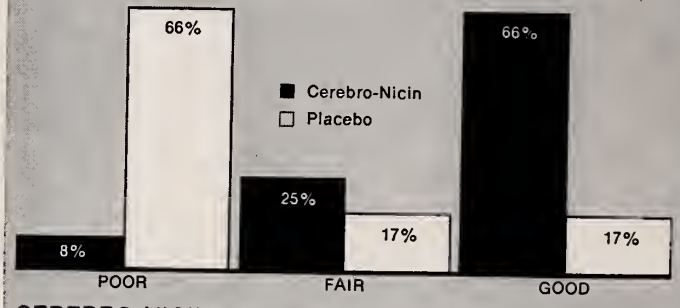
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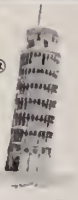
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References: 1. Montesano, P. and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Gubbio, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tillett, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. F. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1958, pp. 79-99.

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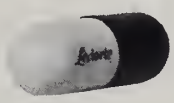

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EDITORIALS

The Dearth And Death Of Privacy

There are some of us who remember when no patient needed to ask: "Please keep this confidential, doctor." That was assumed. But then that was a simple time when the doctor-patient relationship was unclouded. Today, however, we have to give reports, including diagnoses, to employers, Medicare, commercial health insurance carriers, Blue Shield, FBI agents, labor union executives (who question the "unemployable" stamp for some of their members), Social Security (if the wage earner alleges total disability), the welfare department (if he says he is unable to work), and so on and on and on. Of course, we can refuse to send in the data. Then the patient simply will not get the benefit, the indemnity, the explanation, the reimbursement, to which he is entitled.

Congress has been asked to consider creating a national data bank, where in one master file will be stored cards about everyone's credit rating, health, accidents, educational level, injuries, jobs held, persons sued, and so on, apparently without limit.

Even without such a data bank, there is precious little privacy left anyway. From the psychological tests given to the elementary school children, to the Army's 201 file, to the records in any court clerk's files, to the credit ratings patiently accumulated, the area of privacy is shrinking. We like to think of our profession as the last bastion of individual privacy, an honor which we hopefully share with the clergyman.

But how long can we withstand the avalanche of report requests, punch cards, and questionnaires is anyone's guess. Last year New Jersey enacted a physician-patient privileged communication law, but the statute has several holes in the umbrella of confidentiality. It protects only those communications helpful for diagnosis or treatment. It doesn't apply to information collected to give data for a commitment paper, and it doesn't cover information about felonies. Of course, we should be grateful for small favors. New Jersey existed for 200 years without any doctor-patient privilege at all.

You Can't Aim A Bacterium

In July 1969, the United Nations released a report on biologic warfare prepared by a committee of experts. From this we learn that the enemy (anybody's enemy) could spray an area with an aerosol, or even with a powder, containing a culture of *actinobacillus* (or, if you prefer, "malleomyces") *mallei* and spread a plague known variously as farcy, rotz, morve, or glanders. Thought of as a disease of animals, it is easily transmitted to human beings. And, as it is drily put in the Cecil-Loeb textbook: "few patients recover from acute glanders." The UN report says that the disease is "almost invariably fatal" and characterizes sulfonamides and antibiotics (the only known therapy) as having "little effect."

Glanders is a rather nasty disease, and so are several others which are, as of now, so rare in the USA that most of us have never seen a case. The UN report lists such biologic weapons as meliodosis, pulmonary anthrax, bubonic plague, and even small pox, all of which have a very high mortality rate. It seems that the United States and most other civilized nations are seriously experimenting with biologic warfare. (So far as is known, the uncivilized nations are not.) The deliberate production of disease in human beings would seem to be contrary to, shall we say, the best traditions of our profession.

Now it may be alleged that viruses and bacteria are, after all, only weapons of war, and the physician has no more right to be horrified by this than by the injuries and diseases caused by conventional bombs and bullets. There are, however, some reasons why the

doctor of medicine should be especially concerned about biologic warfare. To begin with, you can't aim a bacterium. You could at least try to limit aerial bombing to military targets; and when the shooting starts on a battle field most of the civilians will have already departed. But you can't do that with bacteria. Then too, bombs and bullets are, as it were, one-shot weapons. When a bullet is spent or a bomb exploded, it can't thereafter hurt anybody else. But bacteria are different. They reproduce themselves and the effect of one colony of pathogenic bacteria may echo through many years. To doctors there is a special horror in bacteriologic warfare. Perhaps physicians have no responsibility for the development of, or for defense against, bullets and bombs. But bacteria are in *our* department, and the talents of physicians have to be used in the research, testing, and control of bacterial weapons.

It is, perhaps, just as well that so few physicians are indeed involved in these programs. Most of the scientists working in this field are microbiologists, physicists, biochemists, laboratory bacteriologists, and other Ph.Ds and D.Scs, but relatively few medical practitioners. On the other hand, while this reluctance to involve M.D.s in the program may be an unguent for our consciences, it also leaves responsibility for medical defense and control in areas outside of the community of physicians. Congressman Richard McCarthy of upstate New York did ask the Department of Defense some questions about biologic warfare plans in the USA but was told that such information was "classified." The Congressman then asked the Secretary of Defense about plans for defense against and control of biologic weapons and received an answer signed by Dr. John S. Foster, the Pentagon's number one scientist. (Dr. Foster is a physicist.) Dr. Foster assured the congressman that: (a) strict safety precautions were observed at our biologic warfare installations, (b) that "there is no specific antibiotic therapy available for most biological warfare agents," and (c) that it would take 100 different vaccines to immunize any one against all known biowarfare agents; that the production and administration of 100 different vaccines to 200 million people was "not practical." Dr. Foster then added: ". . . such a program would be injurious to health and require prohibitive expenditures."*

The AMA has not been asked to pass on the question of the ethics of physicians involved in making advances in biologic warfare. Victor W. Sidel, professor of Community Health at the Albert Einstein College of Medicine has said that: "To stay ethical a military physician must do nothing to contribute to the increase in disease or untimely death. If the physician is unable to make these ethical judgments, he may be a good soldier but he has stopped functioning as a physician."

This concept of a doctor's duty to protest this may run into difficulties if an enemy were to use biologic weapons on Americans first. One wonders then, whether this would justify a "no holds barred" reaction on the part of American scientists. It is not unlike the dilemma of gas warfare in World War I, which was started by the Central Powers before the Allies considered it — or the bombing of civilians in cities from airplanes during World War II, where the first strikes were over England in August 1940. In each case, the defending (and ultimately victorious) powers felt that they had to respond in kind. During World War II, it was U.S. military policy not to use gas or biologic weapons unless the enemy did first. But in 1968 Colonel Daniel Crozier (commanding officer of the medical unit at Fort Detrick, Maryland, where most biologic warfare research is carried out) told the American Public Health Association that the "military forces of the USA are interested in biologic warfare from the offensive as well as the defensive standpoint."

One wonders whether the ethos of the situation would require the physician to devote energies to developing and learning how to distribute bacteria and then to methods of treating the victims of such pathogens. It's a neat problem in moral philosophy.

* From page 26 of the July 25, 1969, *Medical World News*.

ORIGINAL ARTICLES

Newark's unenviable position as "the heroin capital of the nation" lends especial immediacy and importance to this program.

Newark, Narcotics, And The Medical School*

Edward A. Wolfson, M.D./Newark

In the spring of 1969, the Division of Drug Abuse in the Department of Public Health and Preventive Medicine of the New Jersey College of Medicine and Dentistry received from the National Institute of Mental Health† a staffing grant for a comprehensive narcotic addiction rehabilitation service in the City of Newark. It is as if the comprehensive narcotic program and Newark were made for one another. Whereas there is considerable disagreement as to the nationwide extent of the narcotic problem, there is no debate about its extent nor its increasing incidence in Newark. Admitting the gross inaccuracy of figures (there is no narcotic registry in Newark), the Newark police state that there are "considerably more than 3,000" addicts in Newark, an unenviable incidence of one to 130. This compares with an over-all U.S. estimate today of one per 2,000 to 4,000. Newark addicts comprise some 35 per cent of the New Jersey total. In 1967, New Jersey showed the greatest numerical increase in addiction in the United States! As of 1968, Newark ranked seven among all American cities in total number of heroin users. Some experts now feel that Newark has passed New York City as the heroin capital of the United States.

Whereas addiction used to be a disease of essentially older Chinese and Caucasians, it is now increasingly a disease of minority groups mainly in the deprived areas. Current estimates of addicts are 50 per cent Negro and 15 per cent Puerto Rican. But it should be noted that addiction is not just a phenomenon of low income or minority groups. Enforcement statistics simply mean that it is this segment of society that is most likely to be arrested for crimes related to drug use. Some addicted individuals, who (by virtue of their economic position, social contacts, or profession) have easy access to narcotics, still manage participation in the mainstream of society. Addiction is now a disease of youth, most users starting in their late teens. Without minimizing the problems in the white suburban groups, however, drug addiction is predominantly a disease of poverty, a problem of the ghetto. When we speak of poverty, the ghetto, and minority groups—we speak of Newark.

Newark is still scarred by the 1967 riots which took 23 lives and caused $10 million in property damage. Thirteen per cent of Newark's citizens are on welfare. In 1967 Newark led the nation in serious crimes per 100,000 of population. More than half of Newark's school buildings are over fifty years old, and a short-

*This work is from the Department of Public Health and Preventive Medicine of the New Jersey College of Medicine and Dentistry, where Dr. Wolfson is Director of the Division of Drug Abuse and Associate Professor of Public Health and Preventive Medicine.

†Division of Narcotic Addiction and Drug Abuse within the NIMH.

age of 9,000 seats necessitates double sessions. In its struggle to cope with the growing burden, Newark has inevitably raised taxes so that its rate is now one of the highest in the nation: $7.90 per $100 of assessed valuation. Just as inevitably, there has been an exodus of store and home owners to the suburbs. Negroes comprise almost 60 per cent of the population, up from 34 per cent in 1959 and 17 per cent in 1950. The health and social problems of Newark are substantial. According to a recent Model Cities application, "Newark has the highest maternal and infant mortality rates, a very high VD rate, and the highest rate of tuberculosis for all the cities." With respect to narcotics abuse in Newark, as in other deprived urban areas, there is increasing morbidity with skin disease, endocarditis, and hepatitis, as well as increasing mortality due to tetanus and overdosage with its resultant respiratory arrest or pulmonary edema. According to a recent study, 16.6 per cent of all cases of viral hepatitis in New Jersey in the 15 to 29 year old age group are thought to be due to injections of illicit drugs; in Essex County, the figure rises to 36 per cent, presumably because of the concentration of drug users in Newark. It is further estimated that 75 per cent of chronic heroin users have hepatitis as determined by clinical evidence of jaundice, liver function tests, or liver biopsy.

Our Division of Drug Abuse (unusual in the United States insofar as it is a major component of a medical school teaching department) will administer a narcotic detoxification unit at Martland Hospital.†† It coordinates the work of six affiliates presently engaged in the treatment and rehabilitation of addicts and each offering a different approach to the problem. It has developed and will administer a Narcotics Registry, and provide for 24-hour emergency consultation and education services. Contracts or agreements with the affiliates include arrangements for referral of patients, sharing of clinical information, coordination of agency programs, and cooperation between the staff of the different agencies and organizations concerned. A key feature of any newly funded program—characteristic of the community mental health center program, and now considered vital in the treatment and rehabilitation of narcotic addicts—will be continuity of care, which assures that a patient moves through treatment and into different facilities according to his needs and rate of progress.

The over-all comprehensive program and future plans of the Division of Drug Abuse are not confined to detoxification and coordination of treatment facilities. Being affiliated with a medical school, the Division is in an excellent situation to develop, administer, and evaluate training programs. We will evaluate the adequacy and efficacy of the existing programs in the city of Newark. One of the basic difficulties with most treatment and rehabilitation programs is the absence of extramural evaluation. Each program inevitably (and justifiably) develops an emotional proprietary interest in its own program and technics, and this introduces a bias which makes valid self-assessment difficult. Since there is no monolithic approach to the treatment of opiate dependence, and since large amounts of public and private funds are now being channeled into the addiction field, it is imperative to have objective evaluation. Without valid evaluation of all programs, large amounts of public and private funds will surely, as now, be wasted on ineffectual programs. An evaluation unit can be most effective if it simultaneously or consecutively assesses a variety of programs using identical, standardized criteria. Ideally, as many evaluation units are developed throughout the country, they will coordinate their efforts so that the assessments will be uniform enough to permit generalizations. Only if this is done can there be a rational approach to rehabilitation of the opiate-dependent individual, and only then can valid determination be made as to where public and private monies should be directed.

The evaluation unit will be particularly interested in the type of addict served by each program, his maturation, duration of drug use, the number of drugs regularly taken,

††Formerly the Newark (N.J.) City Hospital.

family background, educational background, social adjustment, evidence of criminal behavior, psychiatric status, and employment record. His changes in attitude during therapy, subsequent drug use, work record, social adjustment, and criminal behavior will then all be scrutinized not only by reviewing records of the program, but also by interviewing the addict, talking to employers, investigating his family situation and checking court, police, and parole records.

From these data the success rate of any program can be impartially determined. Such a determination will benefit the program itself, will aid those determining public health policy, and will help those responsible for private or governmental fundings of rehabilitation programs. The agreements between each affiliate** and the College specifically state that the affiliate welcomes the role of the Division of Drug Abuse to act as its independent, extramural evaluator. As far as is known, this will be the first time any single agency will act as the evaluator of diverse programs.

Other functions of the Division include a Central Narcotics Registry and training and education. To date, Newark and the State of New Jersey do not have any registry that allows one to determine the extent of the opiate problem. The Narcotics Register was initiated for the purpose of providing the data needed to define the scope of the narcotics problem in Newark and to establish a sound methodology for specialized epidemiologic, demographic, and sociologic research.

The five specific aims of the Narcotics Register Project are:

1. To develop efficient methods of establishing a reliable unduplicated count of narcotics addicts
2. To obtain sound estimates of the incidence and prevalence of narcotics addiction
3. To describe the demographic and social characteristics of the addict population
4. To develop the research potential of the Register by conducting appropriate epidemiologic studies
5. To provide data on the fiscal, manpower, and other requirements for maintaining a Register for the City of Newark and to explore potentialities of expanding the Register to cover the entire State of New Jersey.

The Drug Abuse Division is aware that the rehabilitation of established users is difficult regardless of the treatment modality. For those who use marijuana, stimulants, and hallucinogens (such as LSD) there are no established rehabilitation methods, and where individual psychiatric treatment has been attempted, it has often failed. Since treatment often is unsuccessful, the most sensible approach is *preventive education*. Unfortunately, many of our potential anti-drug educators are inadequately informed on drug addiction and abuse and, therefore, are ineffective.

An effective preventive education program on drug abuse is a natural corollary to the comprehensive program planned for Newark. The treatment and rehabilitation program will serve as the basis for any educational course and will enable all participants to gain firsthand experience in the manifestations of drug abuse. Our Division of Drug Abuse is convinced that motion pictures, brochures, lectures, one-day seminars, or one to two-day workshops, each standing alone, will not adequately provide the needed educational expertise; therefore, the Division proposes to undertake the following program.

The Division will organize two three-week courses each year for 40, 50, or 60 individuals each time. Preference will be given to representatives, chosen by the school because they are articulate, sympathetic, relate well to young persons and are trusted by young persons. Others with major community responsibility will also be accepted and preference initially will be given to people in Essex County.

Each course will consist of:

(a) Lectures by noted authorities representing all facets of the drug scene who will be selected from around the country for their expertise.

**The affiliates presently involved are: Integrity House, DARE, Odyssey House, Mt. Carmel Guild, The New Well, and the State's Neuropsychiatric Institute.

(b) Seminars covering each drug category analyzing the chemistry and pharmacology of the drugs, effects, mechanism of action, toxicity, epidemiology, and laws.

(c) Visits to rehabilitation, detoxification, re-training and referral facilities will be arranged.

(d) Exposure to the best movies and brochures on drugs.

(e) A mandatory reading list will be compiled to permit intellectual input by the participants.

Of interest is the medical student-initiated program that is now starting in eight selected high schools in the Newark area. Following an extensive questionnaire to determine the level of knowledge and the prevalence concerning all drugs of abuse, Doctor Donald B. Louria or myself will give an assembly lecture followed by a question period. More importantly, nine of our fourth year medical students will conduct seminars for small groups of the high school students one to two weeks later.

It is anticipated that the Division of Drug Abuse of the Department of Public Health and Preventive Medicine will thus be able to make a significant public health contribution in a sorely needed area, in a grossly neglected field of study and services.

New Jersey College of Medicine and Dentistry.

New AMA Informational Pamphlet

A pamphlet of unique value to medical societies in their public relations' programs has just been released by the American Medical Association. In its 32 pages are outlines of many public services to protect and advance the health of Americans and the world population.

The American Medical Association . . . Guardian of the Nation's Health Since 1847 summarizes its history and organization. Its real value in contemporary society, however, is in relating the many programs and the cohesive efforts of almost 220,000 member-physicians to promote better health care. The AMA since its founding in 1847 has instituted reforms, improved and expanded medical knowledge worldwide, and has achieved a place of recognized leadership. The association serves not only its membership, the medical community, but also the public, and this pamphlet is intended to illuminate these services "to effect a broader understanding of the association's total functioning."

The booklet is intended for distribution to public audiences, and also is a good refresher for physicians and a primer for medical students and new society members. It is a perfect backgrounding reference for editorial writers, media commentators, and community leaders. It reviews the AMA's scientific meetings, publications, library and record services, medical student and school scholarships and grants, ethics, drugs, mental health, and health manpower recruitment activities.

The entire booklet is updated, and several new programs are covered: Volunteer Physicians for Viet Nam, the Viet Nam Medical School Project, the new Department of Health Care Organization (to accelerate health care delivery systems), proposing and drafting legislative bills, and the innovative proposals of the AMA Committee on Health Care of the Poor.

Other areas with increased emphasis reflect the problems of modern society: alcoholism and drug dependence, health care costs, malnutrition, pollution, sex education, and voluntary health insurance coverage.

Copies of *The American Medical Association . . . Guardian of the Nation's Health Since 1847* are available without cost from Program Services Department, AMA, 535 North Dearborn Street, Chicago, Illinois 60610.

Don't forget the danger of fat embolism after fractures of the long bones. It is commoner than you think.

Fat Embolism

A Problem Of Increasing Importance In Traumatic Surgery*

Vincent A. Scudese, M.D.; Kunikata Hamada, M.D.; and Ariston Awitan, M.D./Newark

With more and more automobiles coming off the belt-lines, with their speeds increasing and their horsepower mounting, with many cars being driven by youths of uncertain judgment or older people with slow reaction time, it seems certain that fractures and their complications will occupy a larger share of the physician's time. The rising incidence of fractures has produced an increasing morbidity. Fractures of the shaft of the tibia and femur are mostly associated with fat embolism. The following cases are being reported because of the increasing failure to recognize fat embolization.

Case 1. A 25 year old man was admitted to Martland Hospital because of injuries to the femur and tibia as a result of an auto accident. Examination and radiographs revealed a displaced fracture of the shaft of the right femur and the shaft of the right tibia. His general condition being stabilized, the patient was taken to the operating room the same day. The fractures were reduced, fixed with multiple pins and immobilized in a long leg plaster cast. At completion of application of the plaster cast, the patient became cyanotic and developed irregular respirations. Blood was administered, but the blood pressure remained at 80/50. Tracheostomy was done and digitalis was administered. Heparin, 50 milligrams, was given intramuscularly every 8 hours. Hematocrit fell to 30 per cent and the hemoglobin dropped to 10 Grams. Serum and urine revealed fat particles. Chest radiographs showed bilateral fluffyness. In spite of vigorous resuscitative measures, he became comatose and died the next day.

At autopsy, the lungs were found to be edematous and congested with small patches of hemorrhages. The brain revealed multiple petechial hemorrhages. Microscopically the lungs showed a mild degree of fat embolism. Fat globules were present in the arterioles. The brain showed typical hemorrhages.

Case 2. A 40 year old man was admitted to the Martland Hospital with closed displaced fractures of the femur and both tibia. Neurologic examination did not reveal brain damage or compression. Skull x-rays were normal. The right femur was immobilized in skeletal traction at the upper tibia with balanced suspension. The left tibia was immobilized in a short leg plaster cast. The patient was fully conscious for five days when he suddenly became confused. Pulse, temperature, and respirations increased. Hemoglobin dropped to 10 and hematocrit to 30 per cent. Tracheal bronchial secretions appeared. Nasal oxygen was given. Urine showed fat particles. Radiography of the chest revealed bilateral fluffyness. Petechial rash over the upper chest appeared two days later. Alcohol in dextrose was given daily. Respirations improved with oxygen therapy. Nasal secretions subsided 6 days later. Restlessness disappeared 5 days later. Fat in the urine disappeared 5 days later. Petechiae disappeared twelve days later.

Case 3. A 28 year old man was admitted to the Martland Hospital two hours after injury to his right leg. He had a comminuted fracture of the shaft of the tibia and fibula. Neurologic examination was normal. About 24 hours after injury he became confused, pale, and dyspneic. Fundi were normal. Large fat particles were present in the urine. Three days later petechiae appeared over the upper front of the chest. Serum lipase was 0.6 units. Masked oxygen was begun. One thousand ml. of 5 per cent ethyl alcohol in 5 per cent dextrose was given daily for the next five days. Restlessness disappeared after five days. Heparin was given intramuscularly (50 milligrams every six hours) every day for five days. Fat in the urine disappeared after three days.

Case 4. A 30 year old woman was brought to the Martland Hospital after being involved in an automobile accident. A large hematoma was present over the left femur. The left lower extremity was shortened and externally rotated 45 degrees. Radiographs showed a fracture of the left femur in the mid-shaft with displacement. The patient was started on 1,000 ml. of 5 per cent glucose in saline. Forty-eight hours following admission she became confused. Hemoglobin and hematocrit dropped. The temperature, pulse, and respirations increased. Both serum and urine revealed fat particles. Chest radiographs demonstrated bilateral fluffyness. One thousand ml. of 5 per cent alcohol in 5 per cent dextrose was given daily for the next 5 days. Heparin (50 milligams every six hours) was given intramuscularly for 5 days. Fat in the urine disappeared on the fifth day. Confusion disappeared on that day, too. Anterior chest petechiae appeared on the fourth day. Three pints of blood elevated the hematocrit from 30 to 35. Ten days later she was alert, fully oriented without cyanosis or dyspnea. The patient was taken to the operating room on March 20, 1969 and underwent multiple pin fixation of the femur.

* This work is from the Martland Hospital Unit of the New Jersey College of Medicine and Dentistry, Division of Orthopedic Surgery.

Case 5. A 20 year old woman was brought to the Martland Hospital after being struck by an automobile. A large hematoma was present over the right femur. The right femur was shortened and externally rotated 45 degrees. Radiographs showed displaced fractures of the right femur and right tibia and fibula. The patient was started on 1,000 ml. of Ringer's lactate. Balanced suspension with traction through the upper tibia was applied. Seventy-two hours later she became confused. Hemoglobin and hematocrit dropped. Temperature, pulse, and respirations all went up. Urine revealed large fat particles. Fat particles were also found in the serum. Chest radiographs revealed bilateral fluffyness. Ethyl alcohol in dextrose was given for the next six days. Urine fat disappeared on the sixth day. Confusion disappeared on the fourth day. Axillary petechiae appeared on the third day and vanished on the twelfth day. Three pints of blood elevated the hematocrit to 40 per cent. Eight days later she was alert and fully oriented without dyspnea. The patient was taken to the operating room and underwent multiple pin fixation.

The beginning of our knowledge of fat embolization began as early as 1669 with the injection of milk by Lower.[13] Zenker,[25] in 1862, observed the first fat emboli in the pulmonary capillaries of man following a severe crushing injury to a railroad worker. Lehman and Moore[11] showed that histamine from necrotic muscles produced disintegration of fat emulsion of normal blood streams. They concluded that fat embolism might be produced in the bone marrow on a non-traumatic basis purely by the absorption of histamine from injured tissue into the blood stream. Jirka and Scuderi[9] were the first to indicate that the roentgenographic (snow storm) appearance in the lung fields represented pulmonary fat embolization. Subsequently Scuderi[9] demonstrated the "sizzle test" for fat. Whenever fat droplets were present a sizzling and popping occurred when a platinum loop was heated over an open flame.

In 1913 Warthin[23] concluded that fat embolism was the most frequent cause of death after fracture of a long bone. In 1924 Gauss[8] suggested that fat was liberated from marrow following fractures and entered the ruptured veins held open by rigid bone. Fuschig[7] showed that the source of fat embolism is depot fat which is mobilized by way of lymphatic channels to the lungs following hemorrhagic shock. Sevitt[20] considered pulmonary fat embolism as a clinical entity when there was an associated cerebral systemic embolization. He stated that fat droplets were found histologically in petechiae. Peltier[18] disagreed and regarded petechiae as being due to accumulations of thrombocytes. He demonstrated hypoxia in animals following pulmonary fat embolism. Benested[2] was the first to report the important clinical sign of the petechial rash which usually appeared on the second or third day about the shoulder, neck, clavicle, and upper chest. Peltier[18] in experiments showed that the use of tourniquets in operations on bones decreased the amount of fat reaching the lungs. Elevation of the limb was of benefit. Herrmann,[26] in 1932, was the first to advocate the use of ethyl alcohol in dextrose.

Pathogenesis

The source of embolic fat remains contested. Gauss[8] suggested that fat was liberated from the marrow following fractures and entered the ruptured veins held open by rigid bone. Peltier[17] and others in recent years have championed this theory of pathogenesis. Fuchig[7] has disagreed and suggested that the source was depot fat which was mobilized by way of the lymphatic channels to the lung following hemorrhagic shock. Lehman and Moore[11] presented the concept that the emulsion stability of blood lipid was altered in fat embolism. Musselman[15] suggested that emboli arose from aggregation of chylomicrons into large fat globules in the 5 to 10 micra range. Numerous investigators have found that blood lipid emulsion stability was closely related to blood coagulation factors. Cullen and Swank[6] showed erythrocyte aggregation and adhesiveness associated with alimentary hyperlipemia after injections of large molecular substances. Bergentz[3] demonstrated alterations in blood cell aggregations and coagulation factors in fat embolism.

Cammermer[4] reported juxtaembolic thrombosis of fibrin. Le Quire[12] furnished further support for this concept. Examination of post mortem lung specimens of patients with fat embolism disclosed birefringement crystals; a positive Schultz test that indicated cholesterol was present in these droplets in excess of 10 per cent. Lasch [10] suggested that this syndrome

may be one of intravascular coagulation defects.

Emboli reaching lungs produced pathologic pictures in several ways. Peltier[17] stated that emboli lodged in lungs produced a mechanical obstruction which may be unnoticed clinically. The fat droplets were acted on by pulmonary lipase, releasing fatty acids. The delayed fatty acid release, he insisted, was responsible for the clinical entity but only when it was associated with cerebral or systemic embolism. He felt that the pathologic picture involved hemorrhagic and ischemic changes following occlusion of small vessels by fat which migrated to the left heart and systemic circulation. A few workers have stressed the importance of the detection of anoxia in pulmonary fat embolism. Collins[5] showed that significant pulmonary impairment may occur following trauma in the absence of symptoms. They believe that this is secondary to fat embolism.

Diagnosis

The syndrome is not difficult to diagnose if one thinks of it. The usual pattern develops in an individual between ages of 20 and 40 who has sustained a fracture to a major long bone. Up to the fourth day following injury, respiratory distress may become apparent with fever, tachycardia, headache, restlessness, delirium, stupor, hemiparesis or coma. Hypotension is not characteristic. Chest roentgenographic changes consist of widespread fluffy densities of a "snowball" pattern. Electrocardiographic patterns may indicate right heart stress. A sudden unexplainable drop in hemoglobin may develop. Petechiae are present over the front of the chest, axillary folds and conjunctiva in 50 per cent of the cases.

Fat globules may be found in the urine and serum. Peltier[18] considers urine fat and elevated lipase levels important in the diagnosis and prognosis of the disease. This is disputed by Morton,[14] Warthin,[23] Nuessle,[16] Scott,[19] and Tedeschi[22] who have found large fat droplets in the urine and sputum of randomly selected patients and normal controls as well as patients who have sustained bone trauma. Diagnosis depends on the analysis of blood gases. Arterial hypoxia will substantiate the diagnosis. Pa O^2 will be decreased while the Pa CO^2 will be increased.

Treatment

Fractures and associated soft tissues must be immobilized. Immediate splints should be applied to prevent undue motion at the fracture site. Delay of operative intervention for 7 to 10 days reduces early mobilization of the fracture site fat. If open reduction is required, the use of tourniquets also favor the non-loosening of fat at the fracture site. Minimal manipulation of open or closed fractures retards extravasation of fat into the blood stream. Following the development of fat embolization, many have advocated heparin in less than anticoagulant doses because of its chylolytic effect. The basis for heparin is theoretically sound but there is no definitive evidence in the clinical situation that heparin used alone alters the course.

Alcohol has been recommended by Alder, Lai and Peltier.[1] Their reasoning is based on the fact that alcohol demonstrates lipase inhibition *in vitro* and therefore should retard the breakdown of neutral fats to free fatty acids, which they think are harmful to the lung. Others feel that alcohol does not aid in emulsification or hydrolysis of fat and probably does little more than make the patient feel better. Dextran and hypothermia are other forms of recommended treatment.

The intelligent use of oxygen is most important. Profound oxygen desaturation may exist with this disorder. Eventual respiratory failure results from severe anoxia and acidosis. Arterial gas measurements are the only way one can judge the severity of the respiratory distress and intelligently treat it. Should mask oxygen fail to improve alveolar ventilation and decrease the work of breathing, mechanically assisted respiration would be mandatory. Oxygen therapy might reduce the amount of systemic embolization if continued embolization is felt to be a factor. The toxicity of

high oxygen concentration for prolonged periods should be kept in mind and its use should be regulated to the needs of the patient. With severe respiratory failure, steroids have been beneficial and their further use in these cases seems justified. Tracheostomy with oxygen installation is indicated in respiratory failure. Any resultant *cor pulmonale* can be treated by digitalization.

Our cases were of interest from several aspects. In the fatal case (case one) the initial autopsy report was that death was due to pulmonary edema. Dissatisfied with this, we requested re-examination of frozen sections of the brain and lung stained with Sudan IV. Subsequent histologic examination then revealed fat embolization within the tissues. The early symptoms of confusion, restlessness, along with elevation of temperature, tachycardia, tachypnea were suggestive of fat embolism. The fall in hemoglobin and the presence of fat in the lung and brain substantiated fatal fat embolization.

Treatment with 5 per cent alcohol in 5 per cent dextrose resulted in rapid improvement in 4 of the 5 cases. Drop in temperature and pulse paralleled the rise in hemoglobin. Arterial gas analysis of oxygen and carbon dioxide were adjusted through the use of masked oxygen.

Large fat particles were demonstrated in all our cases. Microscopic demonstration of large urine particles requires experience and knowledge. After the urine is centrifuged, fat must be stained and immediately examined microscopically. Normal staining multiple small fat particles normally filtered through the tubules must not be mistaken for the fat substance responsible for fat embolization. The large fat particles measuring 10 micra and larger must be identified in order to substantiate urine fat due to fat embolization. Delay in examining urine stained by Sudan IV will demonstrate large artificial fat particles which are *not* due to fat embolization but are caused by physical coalescence.

Currently there are two leading concepts regarding fat embolization. One states that venous extravasated fat following injury produces mechanical pulmonary obstructions. The other relates fat embolization to alteration in the emulsification of plasma lipids. It is likely that fat embolization is due to a combination of both concepts.

Summary

Five cases of fat embolization following a major fracture of a long bone of the lower extremity are reported. One case of fatal fat embolization occurred following a fracture of the tibia and femur on the same side. The initial autopsy diagnosis was pulmonary edema while the subsequent re-examination of frozen material stained with Sudan IV confirmed the presence of fat embolization. The possibility of fat embolism must be kept in mind so that the more commonly occurring fat embolization syndrome may be detected and treated.

—A bibliographic list of 25 citations appears in the author's reprints.

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VISIT THE EXHIBITS

Informational —— Scientific —— Technical

Annual Meeting —— May 16-19 —— Atlantic City

Carbamazepine has been found to be remarkably effective for the lightning-like pains of trigeminal neuralgia, tabes dorsalis; and glossopharyngeal neuralgia.

Carbamazepine For Relief Of Pain And Control Of Convulsions*

Elmar G. Lutz, M.D./Wayne

Though it was originally offered for the control of convulsions, carbamazepine** has provided dramatic relief for the pains of *tic douloureux,* tabes dorsalis, and glossopharyngeal neuralgia.

Clinical experience in the early 1960s showed the drug to be effective in grand mal, in temporal lobe epilepsy, and in post-traumatic convulsive disorders. Most investigators also found psychotropic effects, characterized by positive personality changes, especially marked in the irritable patient with psychoaffective lability.[1] Carbamazepine** (compared to diphenylhydantoin†) significantly reduced the severity of personality disorders in epileptics. No significant difference was found between the two drugs' antiepileptic properties.[2] This "double action" (anticonvulsant and psychotropic) is used to particular advantage in epilepsy. In primary generalized epilepsy and in other types of partial or focal epilepsy, the results of carbamazepine** alone (or in conjunction with other anticonvulsant drugs) were not superior to those of other anticonvulsants. The drug has no specific action against petit mal seizures and no effect on infantile spasms. Average dose in the treatment of epilepsy is between 600 and 1200 milligrams a day for adults. Approximate dosage schedule for children is: up to one year 100 to 200 milligrams a day; from one to five years 200 to 400 milligrams; from five to ten years 400 to 600 milligrams; and from ten to fifteen years 600 to 1000 milligrams a day.

Trigeminal Neuralgia

In 1962 Blom[3] published the first clinical account of carbamazepine** on patients with trigeminal neuralgia. Ten of his eleven patients had remissions within the first 24 hours of treatment with carbamazepine** being administered in a dosage of 400 to 800 milligrams daily. An eleventh patient obtained partial benefit with lessened frequency of attacks. Pain paroxysms usually returned within 24 hours when the effective dose was lowered or the drug withdrawn. A year later, Blom[4] presented a clinical report on 40 patients (27 of them women) ranging in age from 26 to 83 years. Dosage of carbamazepine** was usually 200 milligrams four times daily. The highest dosage administered by Blom[4] was 200 milligrams seven times daily. Thirty-six of the 40 patients obtained complete pain relief within 24 hours after administration of the drug. Two other patients obtained pain relief when carbamazepine** was combined with diphenylhydantoin.† When eleven discontinued the medication them-

* This work is from the Department of Neurology and Psychiatry at St. Mary's Hospital in Passaic, New Jersey.

† Diphenylhydantoin is available under the Parke-Davis tradename of Dilantin®.

** Carbamazepine is available under the Geigy tradename of Tegretol®.

selves, all eleven re-experienced the neuralgia within 24 hours; but the pain was relieved again when treatment was resumed with carbamazepine**. Similar results were reported by Bonduelle, *et al.*,[5,6] Braunhofer and Jesch[7], Burke *et al.*,[8] Dalessio and Abbott,[9] Spillan,[10] and Vandereld.[11] My own experience with carbamazepine** in three cases confirms the experience reported above.

The incidence of therapeutic failures because of non-response or intolerance of drug side-effects necessitating discontinuance of the drug has been 16 per cent in a series of 149 patients tabulated by Bonduelle, *et al.*[6] and 15 per cent in Taylor's series[12] of 52 patients. The most frequent side effects are dizziness, drowsiness, ataxia, nausea, and vomiting. More serious side effects (chiefly of a hematologic nature) are due to bone marrow depression. They include aplastic anemia, agranulocytosis, thrombocytopenia, and transitory leukopenia. Other side effects concern the hepatic, genitourinary, cardivascular, and nervous systems, and the skin.

Baseline blood, liver, and renal studies should be made before and at periodic intervals in the long-term use of carbamazepine**. In view of the number of possible adverse reactions (as listed in the prescribing information of the manufacturer) the conscientious physician might become too timid to use the medication were it not for the patient's final judgment. Using the criteria of patient satisfaction and reluctance to undergo alternate treatment, the success ratio of carbamazepine** may fairly be stated[12] at approximately 85 per cent.

The very occasional severe complications of carbamazepine** treatment still constitute a considerably smaller risk than surgery even in the most skilled hands, especially so since we are dealing most frequently with elderly patients in a poor state of nutrition. These people are more than willing to risk undesirable side effects for the protection this drug has given them. With improved nutrition, and subsidence of the initially existing dehydration, the drowsiness and nausea existing in two of my patients at the beginning of treatment disappeared within one week.

In sharp contrast to the effectiveness of carbamazepine** in *tic douloureux,* patients with other types of facial neuralgia and other paroxysmal pain syndromes do not derive any symptomatic relief. The only two exceptions at this time are glossopharyngeal neuralgia and tabetic lightning pains.

Glossopharyngeal Neuralgia

This is an analogue of *tic douloureux,* which does not share the predilection of trigeminal neuralgia for old age. It causes agonizing paroxysmal and similarly intermittent pain of identical quality in the ipsilateral tonsillar area and often in the middle and internal ear and the auditory canal. As with trigeminal neuralgia, the paroxysmal attacks of pain may be triggered by chewing, talking, drinking, brushing the teeth, washing the face, external touch or even contact with a cool breeze, but most frequently in the beginning by swallowing.

Glossopharyngeal neuralgia is a rare condition. According to Bohm and Strang[13], who over a period of 30 years found only 18 cases in the neurosurgical department of a large Swedish hospital, there was only one case of glossopharyngeal neuralgia for every 100 cases of trigeminal neuralgia. Ekbom and Wexterberg[14], over a five-year period, saw 152 cases of trigeminal neuralgia and four cases of glossopharyngeal neuralgia. Glossopharyngeal neuralgia responds to carbamazepine** in accordance with the therapeutic experience in trigeminal neuralgia[5,6,10,14]. The patients improved within 24 hours. Although three tablets of 200 milligrams a day lead to improvement, four tablets a day are usually needed for near complete pain relief.

Tabetic Lightning Pain

In 1965, Ekbom[15] used carbamazepine** in two tabetic patients who were completely in-

** Carbamazepine is available under the Geigy tradename of Tegretol®.

† Diphenylhydantoin is available under the Parke-Davis tradename of Dilantin®.

capacitated by severe lightning pains. Until now these pains were resistant to any treatment despite adequate antilnetic therapy. Both of his patients became asymptomatic within three days with a dosage of 200 milligrams two to four times daily. The pain recurred almost immediately upon withdrawal of treatment and was again effectively relieved with carbamazepine** within one to two days.

Ekbom[15] compares these tabetic lancinating pains to the pains of trigeminal neuralgia. Both his patients stated that after having an attack they could easily provoke a new bout of pain by gently touching the skin over the painful area. Such areas thus resemble the trigger zones of trigeminal neuralgia.

Alarcon-Segovia and Lazcano[16] recently reported another case of tabetic lightning pain responding immediately to 200 milligrams carbamazepine** twice daily but eventually requiring 600 milligrams after two months and 800 milligrams daily later on for effective symptom relief. In view of neuropathological and clinical similarities between the abdominal crises of tabes dorsalis and acute intermittent porphyria, the investigational use of carbamazepine** in the later condition might prove to be fruitful. It is also conceivable that certain intense lancinating pain episodes associated with multiple sclerosis might respond to treatment with carbamazepine.** Insofar as an autonomic neuropathy and dysfunction appear to be responsible for the paroxysmal pain syndromes of tabes dorsalis and acute intermittent porphyria, such a neuropathy could also be postulated as the pathogenic principle in the still unexplained trigeminal and glossopharyngeal neuralgias.

Comment

The pronounced anticonvulsive effect in preclinical testing suggests that the site of action of carbamazepine** must be at the spinal cord level. Pentylenetetrazol, picritoxin and amphetamine (drugs with "higher" central nervous system actic ı) are progressively less inhibited. The anticonvulsive effect extends over a period of at least eight hours with a peak therapeutic effect within three hours of administration.

Clinical testing established the pronounced inhibitory effect of the new drug on the bulbar linguo-mandibular reflex, a polysynaptic reflex. Polysynaptic reflexes are inhibited but monosynaptic reflexes are hardly influenced. On this basis, Dalessio and Abbott[9] suggest that classic *tic douloureaux* probably represents a disordered state of sensory reflex activity in the brain stem, involving both the main sensory nucleus and the spinal nucleus of the trigeminal nerve.

Thus, interruption of polysynaptic reflex activity, probably also involving autonomic sensory components, appears to be the mode of the specific action of carbamazepine,** accounting for its anticonvulsive effect and for its specific effectiveness for the described paroxysmal sensory syndromes. In this context, it is interesting to mention the high proportion of electroencephalographic abnormalities in patients with trigeminal neuralgia. Almost 50 per cent of the patients in the studies reported by Lennox-Buchtal[17] displayed occasional sharp waves or spikes or slow runs recorded (solely or most frequently) from the temporal lead contralateral to the side of pain. This finding could explain the occasional helpfulness of another anticonvulsant, diphenylhydantoin†, in trigeminal neuralgia. Blom[18] had demonstrated its inhibitory effects on the linguo-mandibular reflex.

The incidence (approximately 15 per cent) of therapeutic failures in trigeminal neuralgia can be further decreased by the combined treatment with carbamazepine** and diphenylhydantoin† as advocated by Blom[1] and Bonduelle,[5,6] and by the addition of neuroleptics.[6]

Although symptomatic in nature, carbama-

** Carbamazepine is available under the Geigy tradename of Tegretol®.

† Diphenylhydantoin is available under the Parke-Davis tradename of Dilantin®.

zepine** at present can be designated as the most potent therapeutic agent for the treatment of trigeminal and glossopharyngeal neuralgia and tabetic lightning pain, and is of considerable use in the treatment of epilepsy.

The symptomatic character of the drug is evidenced by:

1. Almost immediate efficacy of the drug.

2. Rapid recurrence of symptomatology upon discontinuation of treatment or significant reduction of dosage.

3. Symptom relief when medication is reinstituted in adequate dosage.

Carbamazepine** is administered orally. It is available in the form of 200-milligram tablets. The average daily requirement for the paroxysmal pain states is 800 milligrams. This is the initial dosage, divided into four doses, one at each meal and one at bedtime.

Daily requirements vary from 200 to 1600 milligrams. Careful clinical follow-up allows optimal adjustment of quantity and time of distribution of the drug. A residue of discomfort upon awakening is common and can be explained on the basis of the long time interval between two drug doses. It is the general consensus of the investigators that whenever treatment is effective, it acts immediately and at moderate doses. Attempts to interrupt the therapy are necessary to evaluate the need for continued treatment. In some patients, the painful paroxysms no longer recur after discontinuance of carbamazepine**. An occasional patient will become refractory to it.

Close clinical and laboratory supervision (see prescribing information of manufacturer) is mandatory. From a practical standpoint, it can be concluded that carbamazepine** controls the symptomatology of *tic douloureux* and glossopharyngeal neuralgia in most patients. Its use for tabetic lightning pains appears promising. This new drug represents a major therapeutic addition and an attractive alternate to ineffective medical polypragmatism and often unsatisfactory and mutilating neurosurgical treatment.

Carbamazepine** has been approved by the Food and Drug Administration for the treatment of pain associated with trigeminal and glossopharyngeal neuralgia. Its use in this country for the treatment of other pain states and epilepsy is considered investigational and, therefore, subject to all FDA requirements for investigators.

Summary

Dramatic symptomatic relief from the acute attacks of *tic douloureux* (trigeminal neuralgia), glossopharyngeal neuralgia, and tabetic lightning pains can be obtained with a new anticonvulsant drug, carbamazepine.** This is an iminostilbene derivative, related to the imipramine group of compounds.

** Carbamazepine is available under the Geigy tradename of Tegretol®.

A listing of 18 citations to the literature will be found in the author's reprints.

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204TH ANNUAL MEETING

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In chronic staphylococcic infections that had become resistant to other antibiotics, dicloxacillin often proved effective.

Chronic Staphylococcal Infections Of Bone And Soft Tissue*

Treatment with Dicloxacillin

Leon G. Smith, M.D./Newark

For chronic infections, particularly of bone, by the Staphylococcus aureus, a prognosis of "incurability" has come to be more or less accepted. Actually, the outlook for the acute stage has improved dramatically since the availability of antibiotics. Surgery may be of limited value in chronic cases, for it often fails to eradicate the disease after the infection is well established.[1] Continuously discharging sinuses or recurrent reactivation of pain and abscess after intermittent periods of quiescence generally are regarded as inevitable.[2] The great virulence of certain strains of Staphylococcus aureus and their resistance, first to penicillin G (1954) and later to other antibiotics, has complicated the therapeutic picture.

Various strains of Staphylococcus aureus differ in pathogenicity for man.[3] Aside from certain gross predisposing factors, as age (infancy and late life), underlying disease (as diabetes[4]), environment, occupational exposure to infection (e.g., hospital employment), surgical trauma, and immunosuppressive medication, little is known about the liability of the patient to serious staphylococcal infection.[3] Nor is there any clearer understanding of the complex mechanism through which bacteria become refractory to antibiotic substances.

Clinical Series

Twenty-three patients (four of them females) were treated for chronic infections in which the Staphylococcus aureus was suspected or had been demonstrated as the sole or predominant organism. Two were adolescents and two were children. Nineteen were adults ranging in age from 21 to 79 years, with an average of 45 years. In ten of the adults (43 per cent of the group) the infection was well established, having been present for 2 to 13 years (average, 6 years). The remaining adults had been ill up to five months. The children and adolescents had been suffering from staphylococcal infection for from five days to two months. Table 1 lists the clinical diagnoses and the sites of the lesions.

Table 1

Clinical Diagnoses and Sites of Lesions

	Numbers of Patients
Chronic osteomyelitis	
Femur, hip	7
Skull, nose, maxilla	2
Thumb, finger	4
Lumbar spine	1
Ankle, foot	2
Amputation stump, leg	1
Soft tissue infections†	6
Total	23

† Abscesses, ulcers, furuncles, cellulitis and folliculitis.

Serious underlying disease was present in 35 per cent of these patients, mainly in the adults (Table 2).

Of the initial bacterial cultures, six produced

* This work is from the Department of Infectious Diseases, St. Michael's Hospital, Newark, New Jersey. Dr. Smith is chief of that department.

Table 2

Underlying Disease

	Number of Patients	Age yrs.	Remarks
Sickle cell disease	1	16	
Tetralogy of Fallot	1	21	Dropped out
Tuberculous lymphadenitis	1	24	" "
History of pulmonary tuberculosis	1	58	" "
Diabetes mellitus	1	60	
Alcoholic cirrhosis, large hernia	1	67	
Carcinoma of bladder	1	74	
Diabetes mellitus and bilateral pyelonephritis	1	79	
	8 (35%)		

no growth; ten demonstrated the Staphylococcus aureus (coagulase-positive) in pure culture; and in five, the Staphylococcus aureus was present with gram-negative organisms (Pseudomonas, Proteus, Aerobacter, Escherichia coli, and Klebsiella). Two cultures grew the beta hemolytic streptococcus, group A, with other organisms, and in one instance with Staphylococcus aureus. The bacterial growth in each case was tested by the two microgram disk method for sensitivity to dicloxacillin. The staphyloccoci and streptococci present were sensitive; all the other organisms were resistant. All of these patients had been treated previously for their infections; a few, with all known antibiotics and in some cases with surgical measures. Penicillin G, erythromycin, tetracycline, ampicillin, cloxacillin, methicillin and lincomycin had been administered without appreciable lessening of symptoms or influence on the flora of the lesions.

Treatment. Dicloxacillin[5 to 13] was administered in capsules containing 125 milligrams (for the youngest patient) or 250 milligrams, for a total dose of 375 milligrams to 4 Grams per day, according to the severity and chronicity of the infection and, in the children, the weight of the patient. Medication was continued for 7 days to 15 months, as determined by the clinical and bacteriological response. Discharges from the lesions were cultured at various intervals throughout therapy.

Concomitant treatment was prescribed for nine patients. For the tuberculous and the diabetics, appropriate management was employed for the underlying disease. One patient received a short course of ampicillin in addition to dicloxacillin, and another, a course of nafcillin, parenterally. The other five were treated locally with kanamycin, colistimethate, neomycin, polymyxin D, gentamicin, or soaks containing an antibacterial agent.

Therapeutic Response. Table 3 summarizes the details of dosage, duration of treatment, and the clinical and bacteriological response.

Table 3

Treatment of Chronic Staphylococcus Aureus Bone and Other Infections
Clinical and Bacteriologic Response

Number of Patients	Total Daily Dose mg.	Duration days/mos.	Clinical Response	Bacteriological Response
15 (65%)	375 to 4000	10 days to 15 mos.	Cured, or apparently cured	Staphylococci and streptococci eliminated.
1 (4%)	500	7 days	No improvement	Staphylococcus aureus, coagulase + persisted
7 (31%)	500 to 2500		Dropped out	

The first 15 included 6 patients who had been suffering from mixed infections. All have remained symptom-free to the time of this report. Among the 7 drop-outs, one did not return after initial visit; others took medication for varying periods but did not return for blood studies or cultures.

Fifteen patients (65 per cent of the entire series), who had remained under treatment for 10 days to 15 months, achieved an apparent clinical cure, which has continued to the time of this report (summer of 1969) upward of two years.

This group included a 29 year old man who had suffered a severe, chronic Staphylococcus

aureus osteomyelitis of the femur, which had developed after fracture 7 years previously, and had been resistant to all known antibiotics. All symptoms subsided during 10 months of treatment with daily doses of 1 to 4 Grams dicloxacillin and the patient remained well for one year. Then the femur was fractured a second time, which reopened the wound. In 6 months of additional treatment with 2 to 4 Grams dicloxacillin per day, the lesion healed and the patient has been without symptoms and able to work to the present time.

Another patient for 2 years had suffered a chronic bone infection of the ankle by Staphylococcus aureus and Proteus, resistant to all known antibiotics. He voluntarily stopped medication with dicloxacillin at 13 months because symptoms had disappeared and the Staphylococcus had been eliminated from the cultures. Three months later the organism again became active and treatment was resumed. Although symptom-free at present, he probably will have to continue antibiotic therapy for life.

A third patient, a 60 year old diabetic woman, experienced an antibiotic-resistant Staphylococcus aureus osteomyelitis, which developed in the stump of her leg 10 weeks after amputation. Sixty days of unsuccessful medication, including ampicillin, were followed by treatment with 2 to 3 Grams of dicloxacillin daily, and all signs of infection disappeared. She voluntarily stopped therapy in two months. In the subsequent two months the infection recurred, and was controlled by an additional course of dicloxacillin in the same dosage. She since has remained symptom-free.

The one failure occurred in a 6 year old child who had a chronic Staphylococcus aureus osteomyelitis of the foot of 60 days' duration. The organism had been lincomycin-resistant in past treatment, and persisted after 7 days of therapy with 500 milligrams of dicloxacillin daily. Operation was required, after which the infection cleared under medication with nafcillin.

Seven (31 per cent) dropped out of the series. One of the tuberculous patients did not return after the initial visit. The six others, including the man with congenital heart disease and the other tuberculous patient, took the medication for 11 days to 11 weeks, then disappeared. They never returned for blood studies or cultures.

Laboratory studies. All patients (except those who dropped out) were studied before, at frequent intervals during, and after termination of treatment for abnormalities of the blood picture, and of kidney and liver function. (The child who was removed from the series in seven days because of treatment failure received only the pretreatment determinations.) The initial findings were abnormal for 14. The presence of the destructive infection was reflected in the blood studies, particularly in those whose disease had been long established or who had severe underlying problems (alcoholic cirrhosis, sickle cell anemia, carcinoma and diabetes) with hepatic or renal complications. During treatment, the laboratory determinations continued to show abnormalities for 13 patients. In one of these the SGPT values were elevated temporarily, after three months of therapy, but medication was not interrupted. A second patient, suffering from prolonged staphylococcal osteomyelitis for which he had received all known antibiotics without effect, was treated for 13 months with dicloxacillin. Medication was interrupted at 4 months because of a temporary proteinuria, and for one week at 8 months because of an abnormal differential count. Reduction of the daily dose from 3 to 2 Grams resolved the difficulty. In the patient who had suffered two fractures of the femur, a slight, transient albuminuria developed during each course of treatment at a dose level of 4 Grams per day, but subsided without interrupting or altering the medication.

At the final determinations, the liver profile was still abnormal for two patients; and the blood picture and the results of liver and kidney function studies also had not improved for the cirrhotic. For the diabetic with bilateral renal disease, the hemoglobin values remained depressed and the SGOT and blood

urea nitrogen values remained elevated throughout and after treatment. The post-treatment studies on 11 patients yielded normal results.

Side effects. Four patients reported diarrhea on daily dosage of 2 to 4 Grams. In one case this was controlled by reducing the daily dose to one Gram without interfering with the treatment schedule. In another, the diarrhea developed after seven months of medication with up to 3 Grams per day. Treatment was discontinued for four days, after which the dose was lowered to 1 Gram per day. In the remaining two patients the diarrhea was transient, and treatment was not interrupted; the bowel disturbance ceased without altering the daily dose (up to 4 Grams). One patient, who had hemorrhoids, complained that the rectal irritation intensified his discomfort.

Summary

In a study period of two years, dicloxacillin was administered to 23 patients, predominantly male (ratio of 5 to 1) who were suffering from chronic infections (mainly osteomyelitis) in which the Staphylococcus aureus (coagulase-positive) was the sole or principal organism. The beta hemolytic streptococcus occurred in three cases; gram-negative bacteria also were present in six. Eighty-three per cent were adults (average age 45 years). Thirty-five per cent also were suffering from severe congenital, metabolic, or malignant disease, or systemic infection. All had received extensive antibiotic treatment without appreciable benefit.

Dicloxacillin was administered in doses of 250 milligrams (to all but one), for total daily doses of up to 4 Grams, which were continued for 7 days to 15 months, according to the severity and chronicity of the infection. Apparent clinical cure, with elimination of Staphylococci and streptococci, occurred in 15 (65 per cent). In the mixed infections the gram-negative organisms persisted; but all patients became symptom-free. The one failure occurred in the six year old child, who required operation and subsequent nafcillin therapy.

Laboratory studies were done before, during, and after treatment in all but the seven who dropped out, six after varying periods of treatment. The initial findings were abnormal in 14 and reflected the presence of long-standing infection, as well as of the severe underlying disease present in eight. At the post-treatment determinations the liver profiles for four of these, including the cirrhotic and the diabetic with renal disease, were still abnormal. The post-treatment studies for eleven yielded normal results. Four patients experienced diarrhea, which necessitated reduction of the dose in two.

(The dicloxacillin used in this study was the Wyeth brand tradenamed by them as Pathocil.®)

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306 High Street

Transverse myelopathy is rare in even the largest general hospitals. And certainly one would not think of heroin-taking as a factor. Yet here (and previously in only one other reported case) such a lesion was associated with heroin addiction.

Cervical Myelopathy Following Heroin Administration*

William R. Thompson, M.D. and Morton B. Waldman, M.D./Atlantic City

Heroin addicts are subject to many complications of their misfortune. One of these is viral hepatitis. Recovery is to be expected. Not so fortunate is the addict with the recently described transverse myelitis reported by Richter and Rosenberg.[2] Herewith is reported a user of heroin who suddenly developed a cervical transverse myelitis. His complete recovery is doubtful.

A 20 year old man had started to take heroin during August 1968. He took an average of one bag four times per week. For the three days prior to admission he had taken one bag daily. At 9 p.m. on May 5, he injected ¾ of a bag of heroin into the right cephalic vein. Immediately following the injection, he fell to the floor. His landlady discovered him four hours later with the needle still in the vein. She was able to readily awaken him, at which time he discovered that he could not move his fingers or lower extremities. He returned to bed with help and slept for 6 hours. He was brought to the hospital and found to have a complete paralysis of the lower extremities. Pain and temperature sensation was lost below the C7 level. Vibration and position senses were minimally diminished. He was unable to move any of the fingers. Sensation was not present in the fingers. There was minimal resistance to flexion of the neck.

Spinal fluid was under normal pressure. Protein was 62 and sugar 68 milligrams per cent. No cells were present. Myelogram showed no evidence of a filling defect. Serum glutamic oxaloacetic transaminase was 435 units; lactic dehydrogenase 970, and the creatine phosphokinase 530 units. By the next day, creatine phosphokinase had risen to 1075 units. By the 15th day the creatine phosphokinase had fallen to 30, but serum glutamic oxaloacetic transaminase remained high at 226 units. Other laboratory studies were normal.

Prednisone (80 milligrams per day) was started shortly after admission. Dose was tapered down over a three week period. Intermittent priapism occurred for the first few days after admission. An indwelling catheter was necessary to prevent urinary retention. Cystometrogram twelve days later showed evidence of a neurogenic bladder. Rapid improvement of the lower extremity paralysis occurred. He was able to stand by the tenth day. There has been no improvement in the ability to move the fingers. Occasional urinary dribbling occurs, particularly at night.

Acute transverse myelitis is uncommonly seen in most general hospitals. When it does occur, there is occasionally an apparent cause, especially with extrinsic lesions such as trauma, epidermal metastases, or other mass lesions demonstrable by myelography or surgery. Intrinsic myelopathy is often diagnosed by inference, depending upon exposure to a particular virus, history suggestive of multiple sclerosis, or presence of severe vascular disease. It is unusual for a transverse myelopathy to result from the administration of a drug, although it may occur.

It is difficult to deny the existence of a cause and effect relationship in the patient described. The heroin (undoubtedly cut with quinine) is injected and the patient collapses. He awakens four hours later and finds he cannot move his fingers or lower extremities. There are several significant differences between our patient and those described by Richter and Rosenberg.[2] In our patient, the myelopathy was at the level of C7 rather than in the thoracic cord. He was an intermittent user of heroin, although he had taken the

* From the Department of Medicine, Atlantic City Hospital, Atlantic City, New Jersey.

drug daily for the preceding three days, and there was a significant increase in the serum transaminase. This apparently resulted from extensive tissue necrosis in the cord with release of the enzymes into the circulation.

A hypersensitivity reaction seems a most logical explanation. To the heroin or to a cutting agent?

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1925 Pacific Avenue (Dr. Thompson)

Sweden, Sex Education, And The AMA

In its recent *AMA Service Brief,* the American Medical Association reminds us that opponents of family life education in the USA frequently cite: "Look what happened to Sweden after they introduced sex education into their schools!"

According to a "Dear Abby" syndicated column, this indictment falls before the facts. Abby wrote she had been "deluged" with letters and "fact sheets" calling Sweden "a nation of degenerates—leading the world in suicides, alcoholism, divorce, and venereal disease." Her correspondents claim Stockholm is the abortion capital of the world ("no questions asked"), that the unwed mother is glorified, and rape has increased 55 per cent.

Her reply is valuable to teachers, physicians, and parents who are hard-pressed to refute these often-heard charges made by those seeking to sabotage family life education programs. She obtained the following statistics from the United Nations World Health Organization, headquartered in Geneva, Switzerland:

Suicide: In 1968, there were more suicides per 100,000 population in California than in Sweden.

Alcoholism: Both the French and Americans consume more alcohol.

Divorce: In Sweden, one out of every six marriages ends in divorce; in the U.S., one out of every three.

Abortion: Abortion applications must be reviewed by a medical board and the requirements for approval are almost identical to the regulations adopted by the American states which recently liberalized abortion laws.

Rape: Sweden has one of the lowest rates in the world, 1.0 per 100,000 in 1966; the U.S., 5.36 per 100,000 population in 1965, and it increased seven per cent to 5.8 per 100,000 in 1966.

Venereal Disease: Cases of early syphilis reported in 1967, per 100,000 population in Sweden were 4.3; in the U.S., 10.8.

Abby concludes, "Most of us are inclined to accept as 'truths' that which we have heard repeated over and over again. It is for this reason that I have checked out the facts, and present them to you in fairness to a much-maligned and highly civilized nation."

Some 6 per cent of women using the IUCD developed trichomonas, compared with only 3 per cent among women who had depended on a diaphragm.

Trichomonas Vaginalis Infection

Incidence With Use of Various Contraceptive Methods

Allan Lazar, M.D./Teaneck

Cytology smears were received from physicians in private practice, stained and examined by the acridine orange-fluorescence[1] technic and data recorded in terms of cellular abnormality, flora of microorganisms, density of inflammatory cells, and hormonal strength. We then collected information on history, medication, type of contraception, physical findings, and diagnostic impressions. These were coded on punched cards for tabulation.

Included in this study, on a random basis, are 11,197 private patients on whom the physicians provided sufficient data and who met the following criteria: married; under age 50; not pregnant, post-partum, or menopausal; not diabetic; not using any kind of medication (except for the possibility of oral contraception); never having had a major gynecologic surgical procedure; and had not had a minor gynecologic surgical procedure in the past year.

Material for examination was collected with a cotton swab and rolled onto glass slides. The cytology samples were stained by the acridine orange ten-second method of Riva and Turner[1] and examined by the fluorescence technic. After exposure to acridine orange[4], the slide was illuminated by a 100 watt mercury vapor lamp[5] in front of which is a Corning #5113 filter[6]. The nuclei of squamous cells, endometrial cells, and inflammatory cells fluoresce a green-yellow. The cytoplasm of these cells is also green-yellow, but not as bright. Bacteria, trichomonads, monilia, and fungal spores fluoresce a bright red. A Wratten G barrier filter, in the eyepieces of the microscope,[7] stops all light except that which emanates from the cells, and results in a black background against which the cells stand out clearly (Figure 1).

Trichomonas infection was reported on all smears containing the trichomonas vaginalis organisms, regardless of the density of inflammatory response.

Among the types of contraception, nonsequential oral contraception includes all contraceptives in which the same combination of drugs is taken throughout the approximately

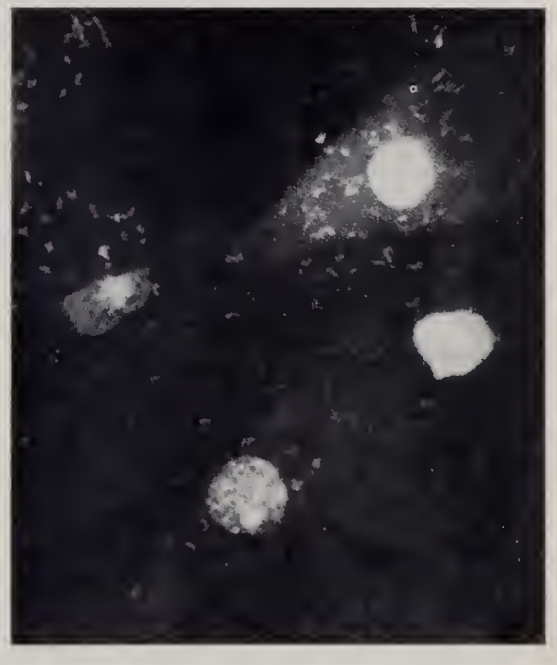


Figure 1—Cytology smear (400 x) stained with acridine orange and examined by the fluorescence method.

The squamous cell (upper right) has a bright nucleus and pale cytoplasm. The three trichomonads are characteristic in shape and have distinct nuclei. Short white objects are bacteria.

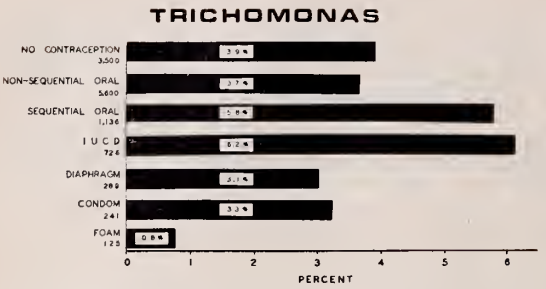


Table 1—Incidence of trichomonas vaginalis infection in groups of women, each group using a different method of contraception.

Private patients; married, under age 50; not pregnant, post-partum, menopausal, or diabetic; using no medication (except for those using oral contraception); and never had a major gynecologic surgical procedure.

Figures under type of contraception indicate the number of women in the group.

21 to 25-day cycle-regimen. (Orthonovum®, Enovid®, Enovid E®, Norinyl®, Provest®, Ovulen®, Norlestrin®, and Ovral®). The non-sequential oral group includes contraceptives in which one drug is taken during the first half of the cycle, and a different drug (or a combination of drugs) is taken during the second half of the cycle-regimen of 21 to 25 days, (C-Quens®, Oracon®, Orthonovum SQ®). Women with an intrauterine contraceptive device (IUCD) were using no additional means of contraception. The group using foam used this alone with no additional medication or device.

The incidence of trichomonas vaginalis infection in groups of women, each group using a different method of contraception, is shown in Table 1.

Considering the "no contraception" group as the "control", the incidence of trichomonas infection is greatly increased among women in the group using IUCD, and the group using sequential oral contraception. The incidence is about the same in the control group and the non-sequential oral contraception group. The incidence is slightly lower in the group using diaphragm and the group using condoms, as compared with the control group. A greatly reduced incidence of trichomonas infection is noted in the group using foam alone; only one case was noted among the 125 women in this group.

Conclusion

The incidence of trichomonas vaginalis infection varies with different methods of contraception. This should be taken into consideration by the physicion in treating the acute infection and also in preventing recurrence.

The author acknowledges the valuable assistance of Mr. David Northrup and Mrs. Yanoff of the computer division of Fairleigh Dickinson University in the compilation of these data.

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204TH ANNUAL MEETING

May 16-19, 1970 Atlantic City

Oxyphenbutazone by mouth and infiltration of the spermatic cord with a local anesthetic were found effective in controlling the pain and disability of epididymitis.

Epididymitis

Response To Different Modalities Of Treatment*

Madhav H. Kamat, M.D.;
Anthony Del Gaizo, M.D.;
and Joseph J. Seebode, M.D./Newark

In its acute stage, epididymitis is associated with severe pain and marked disability, which is out of proportion to the apparent lack of seriousness of the disease. A rational and effective therapeutic measure for the relief of pain (along with acceleration in the resolution of the disease) would be desirable. Many modalities of treatment have been tried. Bed rest with elevation of the scrotum has long been used. Calcium-gluconate has been tried to relieve the pain by its action as a "smooth muscle relaxant." Cold therapy is useful in relieving the pain, but it has no therapeutic value. Hot compresses (or a heating pad) is supposed to hasten the "disappearance of infection" by its hyperemic effect.[1]

Kulenkampff[2] reported the efficiency of injection of a procaine-epinephrine solution around the vas deferens for the relief of pain in epididymitis. Smith[3] found that infiltration of the spermatic cord with a local anesthetic not only resulted in prolonged relief from pain in acute epididymitis, but that it also hastened the resolution of the inflammatory process. Lapides *et al.*[4] reported that oral oxyphenbutazone therapy afforded a remarkable analgesic effect in patients with acute epididymitis.

Impressed by the large number of patients with epididymitis seen at the Martland Hospital of the New Jersey College of Medicine and Dentistry in Newark, we decided to study the clinical response of patients with acute epididymitis to three different modalities of therapy:

(1) bed rest with scrotal elevation and antibiotics;

(2) bed rest, scrotal elevation, oxyphenbutazone, and antibiotics; and

(3) bed rest, scrotal elevation, antibiotics, and infiltration of the spermatic cord with xylocaine hydrochloride.

The third form of therapy was originally initiated to facilitate aspiration of the diseased epididymis. The aspirates are used for microbiologic studies in an attempt to determine the etiology of acute epididymitis.

Material and Methods

From January 1968 to June 1969, we saw 156 patients with epididymitis at Martland Hospital of the New Jersey College of Medicine and Dentistry in Newark. Of these, 54 patients required hospitalization. The five criteria for hospitalizing a patient with acute epididymitis were: (1) severe pain; (2) temperature elevation to 101 or more; (3) age younger than 14; (4) non-reliability of the patient to follow instructions at home; (5) failure of response to out-patient treatment.

Patients were divided into three groups. This

* This work is from the Division of Urology at the Martland Hospital Unit of the New Jersey College of Medicine and Dentistry. Dr. Seebode is Director of the Division of Urology; Dr. Kamat is Instructor in Surgery; and Dr. Del Gaizo is Clinical Instructor in Surgery.

division was at random. Group I patients were treated with bed rest and scrotal elevation; Group II received bed rest, scrotal elevation and oxyphenbutazone (Tandearil®); and Group III patients were treated with bed rest, scrotal elevation and infiltration of the spermatic cord with 1 per cent xylocaine hydrochloride.

Oxyphenbutazone was administered orally in a dose of 100 milligrams three times a day for three days. Repeated blood counts were recorded during the therapy. Infiltration of the spermatic cord was done by injecting 10 milliliters of 10 per cent xylocaine hydrochloride around and into the spermatic cord just distal to the external inguinal ring. This was done only once soon after admission.

If the urethal discharge revealed gonococci, the patient received 2.4 million units of procaine penicillin G intramuscularly. The other patients received demethyl chlortetracycline (Declomycin®) administered orally in 300 milligram doses twice a day for five days, or another form of tetracycline. The patients were discharged from the hospital only after the fever and pain had subsided and the inflammation was resolving.

Results

Response to the therapy was evaluated on the basis of relief of pain and the resolution of the inflammatory process. A *good* response meant that the patients had marked relief of pain within 24 hours and that this relief was maintained thereafter. A *fair* response indicated that the patient had relief of pain within 24 to 48 hours. And a *poor* response meant that the relief of pain was none or only minimal in the first 48 hours.

Results are shown in the Table. In Group I (bed rest and scrotal support) only four out of twenty patients had *good* response, eight had *fair* response, and eight showed *poor* response.

In Group II (bed rest, scrotal support, and oxyphenbutazone) eight patients out of twelve showed *good* response and the remaining four had *fair* response. None of the patients manifested any side effects from the drug.

Group III consisted of twenty-two patients. These patients received infiltration of the spermatic cord on the affected side with 1 per cent xylocaine hydrochloride. Fifteen patients showed *good* response. In these patients, although the numbness disappeared within four hours after infiltration of the cord, the relief from pain was sustained.

In the remaining seven patients, a fair response was obtained. The pain returned after the effect of the local anesthetic had disappeared. All of these patients, however, had complete relief from pain 48 hours after the infiltration. The procedure is quite safe if done carefully. None of our patients had any complications. Average period of resolution of the acute inflammatory process in patients from Groups I and II was six days, although the chronic process continued for six to eight weeks.

In Group III resolution was more rapid and most of the patients were ready for discharge after four days.

All the patients (except one) showed gradual resolution of epididymitis. One patient from Group I required exploration of the scrotum because of persistent pain and worsening of local inflammatory findings. On exploration, the diagnosis of epididymitis was confirmed by the swollen, inflammed and edematous epididymis. There was, however, gangrene of the testes secondary to thrombosis of the testicular artery. There was no torsion of the spermatic cord. This patient required orchiectomy.

Comment

The most commonly used therapy for acute epididymitis is bed rest, scrotal support, and antibiotics. This is effective in bringing about resolution of epididymitis in a majority of the patients. However, the relief of pain is slow and, according to our observation, during the first 48 hours, most patients are severely dis-

abled. Any therapeutic measure that will help to alleviate the pain rapidly and hasten the resolution is, therefore, desirable.

Lapides *et al.*[4] found that oxyphenbutazone† was effective in producing a rapid relief of pain in acute epididymitis. Our findings are consistent with their observation. Two-thirds of the patients who received oxyphenbutazone† had almost complete relief from pain within twelve to twenty-four hours. In the remaining patients, pain subsided within twenty-four to forty-eight hours.

Equally remarkable was our observation of the effects of infiltration of the spermatic cord with xylocaine hydrochloride. Fifteen out of twenty-two (68 per cent) patients showed good response; the relief of pain was obtained soon after infiltration of the spermatic cord with the anesthetic and was sustained.

The remaining patients had a fair response. In addition to the rapid relief of pain, the average period for resolution of the acute inflammatory process in the epididymis was also shortened. This observation is not new. Imbert[5] believed that the pain, swelling, and redness are largely caused by a neurovascular disorder and that the blocking of sympathetic nerves to the testicle by infiltration of the spermatic cord with a local anesthetic may bring about rapid relief of pain and rapid recovery. Smith[3] treated 12 patients with infiltration of the spermatic cord and had a favorable response in the relief of pain and hastening of resolution. A more detailed study which will include consideration of other variables such as age of the patient, duration of the epididymitis, the severity of the disease, and so on, is necessary for more accurate evaluation.

Summary

Acute epididymitis is associated with severe pain and marked disability. Its response to three different modalities of therapy is evaluated. The orally administered oxyphenbutazone or the infiltration of the spermatic cord with a local anesthetic are found effective in obtaining a rapid and sustained relief from pain. Antibiotics are indicated in all cases until the etiology and pathogenesis is better understood.

TABLE

	Responses			
	Good	Fair	Poor	Total
GROUP I (Bed rest, antibiotics, and scrotal support)	4	8	8	20
GROUP II (Bed rest, scrotal support, oxyphenbutazone, and antibiotics)	8	4	0	12
GROUP III (Bed rest, scrotal support, antibiotics, and infiltration of the spermatic cord with 1 per cent xylocaine hydrochloride)	15	7	0	22

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† We used the Geigy brand of oxyphenbutazone, tradenamed Tandearil®.

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Continuing Education Needs For New Jersey Physicians

Alvin A. Florin, M.D. and James P. Harkness, Ph.D./East Orange*

Educators responsible for and committed to the continuing education of physicians sometimes question the effectiveness of their programs. However, few scientific attempts have been made to evaluate the worthwhileness of particular approaches to continuing education for physicians. Consequently, medical educators have few ready guidelines available to assess either their current efforts or the emerging educational needs of the practicing physican for future program planning.

When new developments take place in medicine, they become suitable topics for lectures, panels, seminars, symposia, and workshops. But educators feel obliged to review standard areas of medicine, allowing the practicing physician to refresh his knowledge about established procedures and technics.

One of the major objectives of the Regional Medical Program, as outlined in Public Law 89-239, is the dissemination of the latest medical information to the practicing physician. In implementing this charge, many Regional Medical Programs have reviewed methods of continuing education and explored the feasibility of incorporating modern electronic modalities of communication including television, closed-circuit, two-way radio conferences, audio visual aids and adaptation of telephone networks into established or new teaching programs. Many of these communication methods are applicable not only to teaching but also to diagnostic and treatment procedures. Remote rural areas of the country, where the practicing physician finds it difficult to achieve face-to-face consultation with his specialty colleague, seem to be especially suitable for the adaptation of these methods.

Strengthening medical care through continuing education of the practicing physician is also one of the goals of the New Jersey Regional Medical Program. To assess physician needs and current opinions on the topic, a special survey was conducted during the summer of 1968. Twenty medical students from the New Jersey College of Medicine and Dentistry were provided with interview schedules and self-administered questionnaires. The recruitment of medical students served several purposes. First, it provided the Regional Medical Program with an interviewer who would most likely be accepted by the practicing physician. Second, it offered first-year medical students an opportunity to work in the medical field during the summer months. Third, it provided an opportunity for future physicians to learn, first-hand, the attitudes practicing physicians have about continuing education and the ways in which individuals approach the problem of keeping up to date on scientific advances in medicine.

We reviewed the activities of other Regional Medical Programs in this area. Particularly useful was the mailed questionnaire constructed by the Greater Delaware Valley Regional Medical Program. With the permission of officials from the Greater Delaware

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Valley RMP, parts of their questionnaire were incorporated into the final instrument. Directors of Medical Education in community hospitals throughout New Jersey were invited to a series of meetings on planning the survey. At these meetings, they explored the kind of information which would be helpful for developing stronger continuing education programs in the region. At this session, one group of educators contended that physicians' needs in continuing education can be determined only by asking the physician what his needs are. Another group maintained that the disease entities encountered by the physician during his routine practice of medicine provide the information necessary for selecting topics in educational programs. The logical compromise for the investigators was to include both topics in the final questionnaire. Thus, our self-administered questionnaire reviews the topics physicians wish to see discussed in education programs (along with priorities) within heart disease, cancer, stroke, and related diseases. In the second part, the physician is asked to relate the frequency with which he encounters disease entities in his practice.

The student was instructed to discuss the *methods* of continuing education with the physician. The discussion started with the established methods and ended with a review of the more advanced technics that have been developed recently. Students also attended sessions with the Directors of Medical Education and the Regional Medical Program staff to develop the questionnaire and were assigned background material on graduate physician education. Once the questionnaire was constructed, they attended a full day orientation meeting. Initially, each student was assigned to a Director of Medical Education in hospitals throughout the state.

Directors of Medical Education were asked to bring the students in contact with those physicians who would be most cooperative, so the student had a comfortable start and positive working relationship for the beginning of his summer's work. After initial interviews, however, each student developed his own way of getting into contact with physicians, using lists of the affiliated physicians of the hospital supplied by the Director of Medical Education and directories supplied by the RMP staff. If and when these lists were exhausted, the student moved to the next nearby hospital and on his own, through the experience of the early summer work, contacted physicians for interviews. Thus, the sample became more random and less biased in the sense that all physicians were given a chance of being selected by the interviewer in the particular area. Because of the topics of heart disease, cancer, stroke, and related diseases involved, the students were asked not to interview psychiatrists.

In all, the students were able to interview 525 physicians, a 5 per cent sample of all physicians in our state. The sample closely matched the urban and rural distribution of physicians (¼ rural, ¾ urban). The following table compares the specialty practices of all New Jersey physicians (9,000+) with the 430 in the sample.

Physician Specialties by the State of New Jersey and Respondents in Survey by Per cent

Specialty	*Per cent N. J.*	*Per cent Survey*
Internal Medicine	14	22
General Practice	27	20
General Surgery	10	15
Obstetrics & Gynecology	7	9
Pediatrics	6	5
Urology	2	4
All Others*	34	25
	100	100

*Includes: pathology, anesthesiology, orthopedic surgery, otolaryngology, thoracic surgery, neurological surgery, ophthalmology, psychiatry, and others; each category 3% or less.

Of the 430 responding physicians, 373 or 88 per cent had full-time practices; 400 or 93 per cent were involved with private direct patient care; 17 or 4 per cent were involved with nonprivate direct patient care; and 13 or 3 per cent were involved in medically related activities.

Results

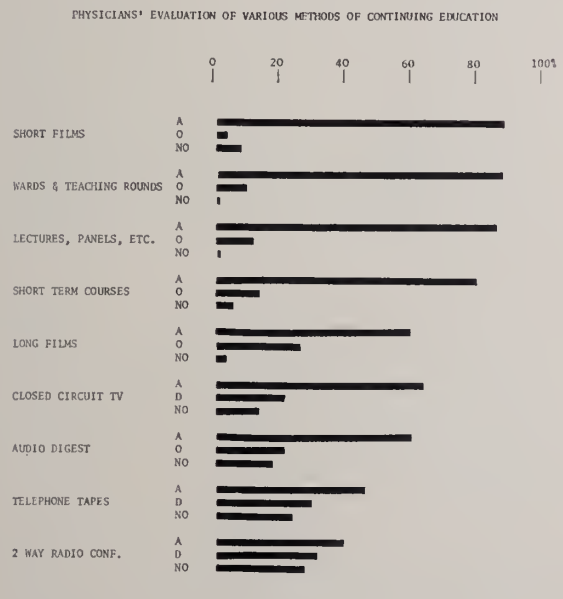
As was anticipated, the most frequently seen condition was hypertensive cardiovascular


CONDITIONS MOST FREQUENTLY SEEN
(AT LEAST WEEKLY)
REPORTED BY NEW JERSEY PHYSICIANS IN PERCENT
0 20 40 60 80 100%
HYPERTENSIVE CARDIOVASCULAR DISEASES
OBESITY AND NUTRITIONAL DEFICIENCY STATES
ANXIETY REACTIONS WITHOUT SOMATIC SYMPTOMS
HEART DISEASE, ARTERIOSCLEROTIC AND DEGENERATIVE
DIABETES MELLITUS
PSYCHONEUROTIC SOMATIZATION REACTION
BRONCHITIS, CHRONIC AND EMPHYSEMA
VARICOSE VEINS AND HEMORRHOIDS
MENOPAUSAL DISORDERS
HEART FAILURE
MENSTRUATION, DISORDERS OF
PERIPHERAL ARTERIAL INSUFFICIENCY
IRON DEFICIENCY ANEMIAS
MYOCARDIAL INFARCTION
CARDIAC ARRHYTHMIAS
PEPTIC ULCER
DEPRESSIVE REACTION STATE
DIVERTICULITIS
CHOLELITHIASIS
BRONCHIAL ASTHMA
SYNOVITIS AND BURSITIS
NEURALGIA AND NEURITIS
MALIGNANT DISEASE, EMOTIONAL EFFECT OF
HEART DISEASE, RHEUMATIC
PROSTATE, HYPERPLASIA OF
BRAIN DAMAGE, ORGANIC
SINUSITIS, CHRONIC
CEREBRAL HEMORRHAGE, EMBOLISM AND THROMBOSIS
SCIATICA
FRACTURES
GOUT
INFLUENZA
MIGRAINE
THROMBOPHLEBITIS AND THROMBOEMBOLIC DISEASE
ALCOHOLISM, CHRONIC
PNEUMONIA
HEPATITIS AND CIRRHOSIS
PELVIC INFLAMMATORY DISEASE
STROKE, EMOTIONAL EFFECT OF
PYELONEPHRITIS
RHEUMATOID AND OSTEO-ARTHRITIS
UTERUS, FIBROIDS OF
HEAD INJURY
INTERVERTEBRAL DISC, DISPLACEMENT OF
CARDIAC ARREST
PULMONARY FIBROSIS, DIFFUSE
BREAST, CANCER OF
BURNS
COLLAGEN-VASCULAR DISEASE
0 20 40 60 80 100%
GONORRHEA
HEARING LOSS
PERNICIOUS AND OTHER HYPERCHROMIC ANEMIAS
SEXUAL PSYCHOPATHY
HEART DISEASE, CONGENITAL
EPILEPSY
UREMIA
COLON AND RECTUM, CANCER OF
GOITRE, SIMPLE & NON-TOXIC NODULAR
MENTAL DEFICIENCY
RENAL CALCULI
STERILITY
NEPHRITIS AND NEPHROSIS
SKIN, CANCER OF
LUNG, CANCER
PARANOID STATES
PURPURA AND OTHER HEMORRHAGIC DISORDERS
UTERUS, CANCER OF
PROSTATE, CANCER OF
URETHRAL STRICTURE
LEUKEMIA
OSTEOMYELITIS
PANCREATITIS
PSYCHOSES, ORGANIC
HISTOPLASMOSIS AND COCCIDIOIDOMYCOSIS
MALIGNANCY OF MOUTH, PHARYNX AND ESOPHAGUS
MULTIPLE SCLEROSIS
RHEUMATIC FEVER
STOMACH, CANCER OF
SYPHILIS
ADDICTION, DRUG
AORTIC ANEURYSM
BLADDER, CANCER OF
GLAUCOMA
KIDNEY, CANCER OF
OSTEOSARCOMA
REGIONAL ENTERITIS
SARCOIDOSIS
THYROTOXICOSIS
ULCERATIVE COLITIS
ADRENO-CORTIAL DISORDERS
LYMPHOSARCOMA
MELANOMA, MALIGNANT
OVARY, CANCER OF
SILICOSIS AND ASBESTOSIS
PANCREAS, CANCER OF
THYROID, CANCER OF
TUBERCULOSIS
MUSCULAR DYSTROPHY
MYXEDEMA AND CRETINISM
PITUITARY DISORDERS

disease. The next two most commonly encountered conditions in order of frequency were essentially "non-disease related," being obesity and anxiety reactions. The fourth most commonly seen condition was arteriosclerotic and degenerative heart disease followed by conditions relating to diabetes. The next four conditions were unrelated to heart disease, cancer or stroke, and chronic congestive heart failure was the last of the first ten most commonly encountered conditions. A cross tabulation was made on several diseases and no relationship was found between conditions and selected characteristics of physicians including age and place of practice.

The physician interview opened by discussing methods of post-graduate education, beginning by assessing the more established and traditional approaches and ending with more recently developed technics. Chart I describes the responses in per cent. Approvals are classified into three categories; unqualified, general, and with qualifications; all disapprovals were grouped.

Physicians evaluated various methods of continuing education as follows:



1. Generally, the more established methods are preferred.

2. Short films are ranked very high.

3. Two-way radio conferences and other new methods ranked lower.

4. Closed circuit TV ranked higher than other new methods.

The high rank of ward and teaching rounds and short films has important implications. Usually, only larger hospitals with strong intern and residency programs have established ward and teaching rounds. Short films, on the other hand, are potentially available to all physicians regardless of hospital affiliation. This suggests that more aggressive approaches to make short films available to practicing physicians may be well received.

Specific responses to short films as a method of continuing education for physicians were as follows:

All Responses	*Per cent*	
Total Number—486		
Very good	14	
Generally good	51	
Good with suggestions	7	
Good with reservations	15	87
No opinion/No answer	7	
No experience	1	8
Bad	5	5
		100

Types of Responses

Favorable	*Unfavorable*
Good for specialist	Too short
Good—surgical technics	Obsolescence problems
Good, depending on quality	Too mechanical
Good Idea: film library	Too superficial
Good—quick review	Little or no value
Good, depending on content	Motivation problem
Good in office or home	Too limited in scope
Good with other methods	Not applicable
Good for GPs	Lack of time
Other	Too elementary
	Too boring

The surprising number of favorable responses to this method suggests the timeliness of introducing this approach to educational programs. A promising new application is a commercially designed attachment which will convert any television receiver into a projector

through the insertion of a tape cartridge. Once tapes on medical subjects are developed and the attachment becomes commercially available, individuals will be able to listen and see medical subjects on new developments, refresher topics, and so on, in the privacy of their own homes and at their own convenience.

Specific responses to wards and teaching rounds as a method of continuing education of physicians were as follows:

All Responses	*Per cent*	
Total Number—574		
Very good	31	
Generally good	17	
Good with suggestions	15	
Good with reservations	24	87
Not available/No comment	3	3
Prefers other means	2	
Not so good	6	
Bad	2	10
		100

Types of Responses

Favorable	*Unfavorable*
Keeps you up to date	Lack of time
Good teaching experience	Lack of attendance
Visiting chief—good idea	Scheduling problems
Enjoy patient contact	Not available locally
Good for interns	Not enough of them
Good for residents	None in M.D. specialty
Good for GPs	Other
Other	

Physicians unqualifiedly approved this teaching method. Many of the unfavorable responses were related to logistic problems in scheduling teaching and ward rounds rather than an opposition to the technic itself. The remainder covered a combination of reasons unfavorable to the general method and included such responses as no interest, lack of clinical material, and interference with hospital policy.

Specific responses to lectures, panels, seminars, symposia and workshops as a method of continuing education for physicians were as follows:

All Responses
(Includes detail of favorable and unfavorable)

	Per cent	
Total Number—554		
Approved generally	38	
Approved unqualified	12	
Approved with suggestions	6	
Approved but practice hinders participation	20	
Other approvals	10	86
Indifferent	3	3
Disapproves (not best way to learn)	4	
Disapproves (boring)	3	
Other disapprovals	4	11
		100

Eighty-six per cent approved this established method of continuing education. The 14 per cent who were indifferent or disapproved expressed a variety of reasons including boring, not applicable, and not the best method of learning.

Specific responses to short-term courses as a method of continuing education for physicians were as follows:

All Responses	*Per cent*	
Total Number—577		
Approve wholly	20	
Approve generally	26	
Approve with suggestions	14	
Approve with reservations	19	79
Indifferent	7	7
Disapprove	14	14
		100

Specific responses to various aspects of short-term courses as a method of continuing education for physicians were as follows: (Numbers include only those responding to specific questions)

Question of Stipend	*No.*
Favor stipend	53
Do not favor stipend	166
Time available per year for short-term courses	
1 week or less	100
1 to 2 weeks	53
More than 2 weeks	22
Courses attended per year	
1 Course	37
2 Courses	19
3 Courses	9
4 or more Courses	2

Preferences	*No.*
Specialty courses	29
General courses	8
Local courses	15
Out-of-town courses	9
Problems Encountered	
Course coverage	44
Financial needs	20
Pressures of practice	26
Lack of time	86
Obligations, teaching, family & unspecified	7

Some significant trends observed include the general disapproval of stipends. Most had one week or less of time available. Only a little more than 10 per cent attended short-term courses. Most prefer specialty courses in their local areas. The pressure of practice keeps many from attending courses and a surprisingly large proportion felt that no courses were available to meet their needs.

Specific responses to long films as a method of continuing education for physicians were as follows:

All Responses	*Per cent*	
Total Number—565		
Very good	13	
Generally good	33	
Good with suggestions	5	
Good with reservations	18	69
No opinion	2	
No experience	2	4
Not too good	25	
Bad	2	27
		100

Type of Responses

Favorable	*Unfavorable*
Good with discussion following	Too long
Good with other methods	Too dated
Good for specialists	Too boring
Good—surgical procedures	Not applicable
Good for keeping abreast	Too elementary
Good with live presentation	Lack of time
Good with complete coverage	Too mechanical
Good if applicable to practice	Other
Other	

Of all the more mechanical (as opposed to personal) teaching technics, this modality has been available for the longest period of time. While long films are favorably received by many, the major objections include the length of presentation and the factor of rapid obsolescence of material.

Specific responses to closed circuit television as a method of continuing education for physicians were as follows:

All Responses	*Per cent*	
Total Number—570		
Very good	9	
Generally good	26	
Good with suggestions	15	
Good with reservations	11	
Good, no experience	2	63
No comment	14	14
Not so good	19	
Bad	4	23
		100

Type of Responses

Favorable	*Unfavorable*
Good—surgical technics	Inferior programming
Good idea: home or office	Scheduling problem
Good for specialties	Too mechanical
Has possibilities	Lack of time
Good for large groups	Too boring
Good idea: channel 31-UHF	Poor attendance
Good with other methods	Other
Good—should be more	
Other	

This relatively new educational medium has not been generally available in New Jersey. The high ratio (63 per cent) of favorable responses indicates that it may be well accepted among physicians.

Specific responses to audio digest as a method of continuing education for physicians were as follows:

All Responses	*Per cent*	
Total Number—494		
Very good	8	
Generally good	35	
Good with reservations	13	
Good with suggestions	3	59
No opinion	5	
No experience	13	18
Not too good	18	
Bad	5	23
		100

Types of Responses

Favorable	*Unfavorable*
Good in automobile	Too expensive
Good: home or office	Lack of time
Good for review	No good for specialists
Good if detailed	Not necessary
Good with other methods	Too long
Good for specialists	Too boring
Good for GPs	Too mechanical
	Too superficial
	Lack question and answer
	Dangerous to drive and listen
	Other

Taped cartridges of medical information are generally favorably received and the greatest utilization occurs while driving in the car. Expense and lack of time were the two major reasons for rating this method as unfavorable for continuing education.

Specific responses to telephone tapes as a method of continuing education for physicians were as follows:

All Responses	*Per cent*	
Total Number—571		
Very good	6	
Generally good	21	
Good with suggestions	2	
Good with reservations	14	
Good, no experience	2	45
No comment, No experience	25	25
Not too good	25	
Bad	5	30
		100

Types of Responses

Favorable	*Unfavorable*
Good for refresher or review	Unnecessary
Good for GPs	Not applicable
Good for keeping abreast	Prefers literature
Good for specialists	Not good for specialists
Good in emergency	Too mechanical
Good for precise points	Not enough information
Good with other methods	Of limited value
Good if varied topics	Lack of time
Good for consultation	Too short
Good for residents	Gimmick or fad
Good for home use	Other
Good for convenience	

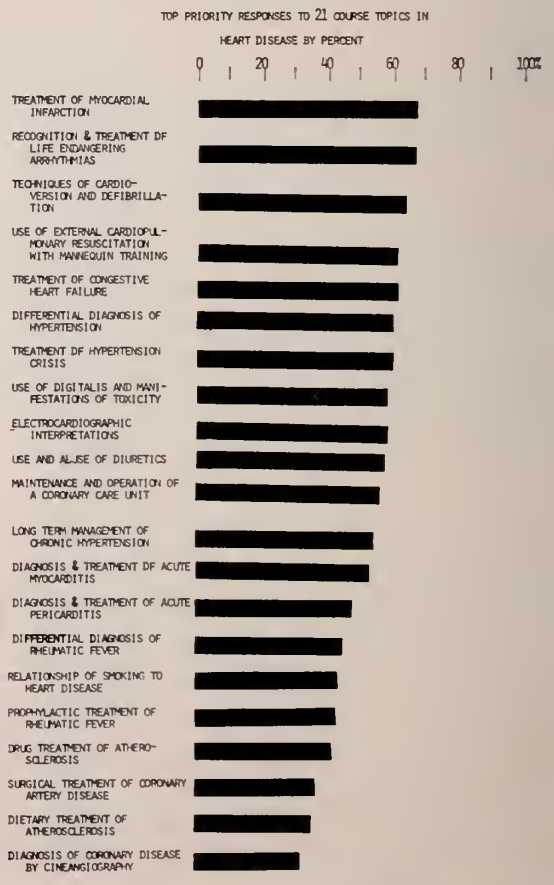
One-fourth of the physicians have not had any experience with this latest method of making medical information available by toll-free telephone. Since the spring of 1969, New Jersey Regional Medical Program has begun this telephone tape program of short (4 to 7 minutes) single concept taped subjects. Presently, 50 calls weekly are received for topics in a 75-tape library. Evaluation of the program is currently under way, and results will be reported soon.

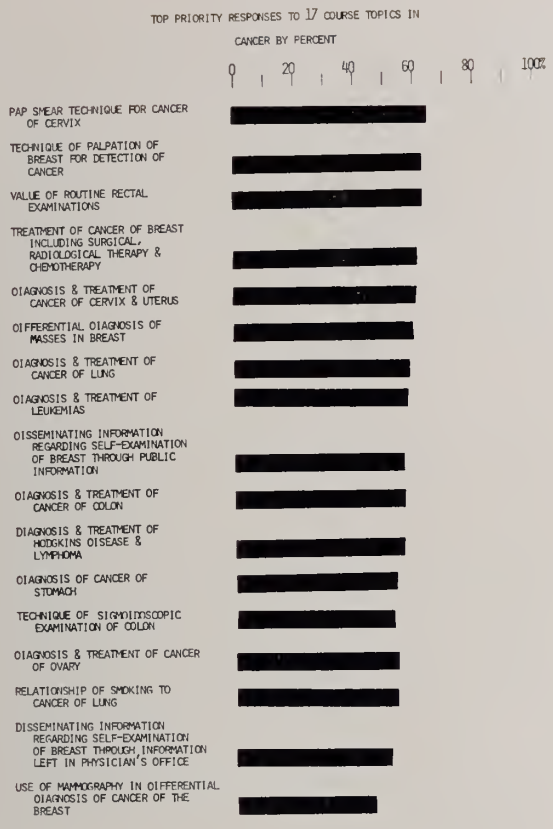
Specific responses to two-way radio conference as a method of continuing education for physicians were as follows:

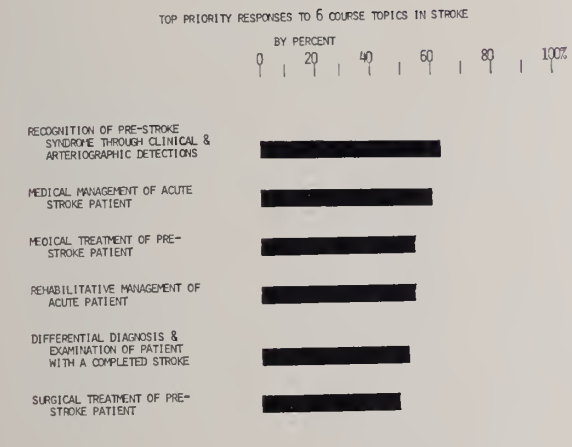
All Responses	*Per cent*	
Total Number—581		
Very good	8	
Generally good	9	
Good with suggestions	5	
Good with reservations	13	
Fair	4	39
No opinion	9	
No experience	19	28
Not so good	13	
Bad	20	33
		100

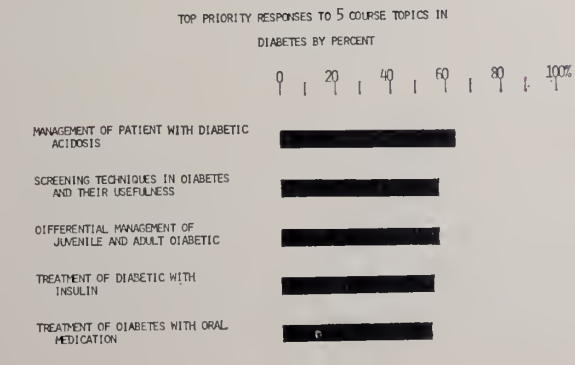
Only a few selected places for two-way radio conferences are available to practicing physicians in New Jersey. Its acceptance as a teaching tool is least promising, but it did appeal to over one-third of those physicians interviewed. Interviewers were unable to secure detailed reasons for unfavorable responses.

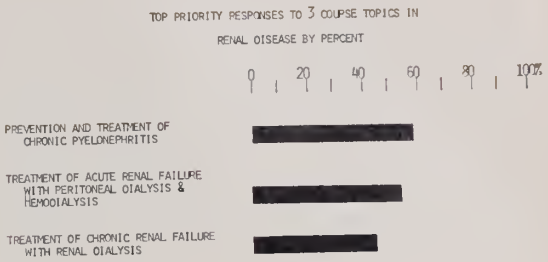
Finally, physicians were asked to rate course topics in heart disease, cancer, stroke, and related diseases. Top priorities were given to the following subjects:











Summary and Conclusion

Our findings reveal a lack of consensus on the most effective method of post-graduate education. Physicians endorsed a variety of approaches. This variation suggests that those mounting continuing education programs should include every available approach that appears to have acceptability rather than rely upon one single method. Despite new technics and devices to attract the attention of physicians, ward and teaching rounds still remain popular. Because many hospitals do not provide this opportunity, programs aimed at developing and encouraging teaching rounds should be high on the list of development priority. Too often, physicians most in need of continuing education, for one reason or another, do not avail themselves of current opportunities. Attracting this group may require the introduction of new methods with the following features:

1. Availability to the physician at his convenience
2. Easy accessibility
3. Acceptability
4. Brief presentations
5. Single topic focus
6. Privacy of presentation
7. Timeliness and pertinence of subject matter

The most promising technic appears to be an audio-visual, short, single concept presentation available at the convenience of the physician with some element of privacy.

A recent development in the audio-visual field appears to meet these requirements. A commercial company has developed a system of audio-visual cartridge tapes which can be viewed over home television receivers. The device provides the means to re-tape existing programs as well as to develop new material. Because almost every physician

has a home television receiver, the device is universally adaptable. Once more, the physician could view educational materials in the privacy of his home at his own convenience. The device will stop the film at any frame and move the film backward or forward, frame by frame, facilitating study of charts, diagrams and more complicated materials.

The detailed report on most frequently seen conditions may be useful for those planning continuing education courses as it indicates the types of diseases that physicians most often see. New developments in any of these areas should be transmitted to physicians as quickly as possible for the greatest impact on improved patient care.

7 Glenwood Avenue

Anti-Quackery Literature

Health Quackery—Cancer is one of a series of pamphlets developed by the AMA Department of Investigation. It warns of alleged new remedies, secret remedies, and other deceptive "treatments" which cost the public millions of dollars each year. The pamphlet tells the public that indeed most cancer patients can be cured . . . if treated properly and in time, stressing that time is of the essence. It points out that dependence on an unproved product or method promoted by the quack often steals away this precious time.

"Some people can't tell the difference between the hokum of an unscientific cultist and the proved methods of a doctor of medicine," the copy reads. "Some grasp at any straw, no matter how fraudulent the product or method. Some seek to avoid the cost of orthodox treatments, apparently not realizing that quack treatments can cost their lives as well as money."

In addition to listing cancer's seven warning signs, the pamphlet debunks many of the ersatz cancer treatments and remedies. *Health Quackery—Cancer* has two companion pieces. Other titles are *Health Quackery—Arthritis* and *Health Quackery Devices.* Single copies of each are 15¢; lower prices for quantity purchases. Write to the AMA Order Department, 535 North Dearborn Street, Chicago, Illinois 60610.

Building A Better Mousetrap

As a continuing part of its health education program, the American Medical Association offers two new "Timely Tips"—*Building A Better Mousetrap* and *Two In Every Hundred.* These single-page leaflets are excellent enclosures in physicians' monthly statements and for distributing at schools, fairs, and other public gatherings.

Building A Better Mousetrap discusses the three dangerous U.S.A. rodents which cause a billion dollars of damage annually. The tip describes each type of rodent, points out how to detect them, and provides information on exterminating them.

Two In Every Hundred points out that at least two people in every hundred have diabetes, but only one of them is aware of it. Describing diabetes as the eighth cause of death and the third-ranking cause of blindness, the tip explains the nature of the disease and describes its warning signals. It advises that the clue to successful control is early detection.

Each "Timely Tip" is available in quantities of 100 for only 20¢. Previously published tips on 12 different health subjects may be ordered in a "package" of 100 each for only $1.50 from the AMA Order Department, 535 North Dearborn Street, Chicago, Illinois 60610.

Special Article

AMA Reacts To Medicare Critics

The Senate Finance Committee has approved a report on medicare and medicaid which was critical of both physicians and administration of the health care programs. It included a recommendation for fee schedules for physicians' services.

In a joint statement, the presidents of the American Medical Association and the National Medical Association pledged support of their organizations to efforts to correct deficiencies and abuses in the two programs. However, the two spokesmen for organized medicine said "it would be tragic if . . . regulations were adopted whose effect would be to deny a greatly improved level of health care to the ghettos."

The AMA-NMA statement said that "we were encouraged by the committee's comment that it 'believes that the majority of physicians for whom information was requested with respect to medicare and medicaid as presently structured have dealt fairly with these federal programs . . .'"

In regard to abuses and fraud, the statement said:

"Where these abuses exist, they must be rooted out. Both the AMA and the NMA are prepared to take vigorous action to help the committee and the government accomplish this." It was noted that the committee had denied an AMA request many months ago that it be given the names of physicians involved in the committee's investigation. "Despite this," the statement said, the AMA and the NMA through their own resources have been able to identify a number of physicians grossing more than $25,000 . . .

"In some instances, medical societies had already taken appropriate action against individual physicians where the evidence warranted. In other instances, however, the AMA and the NMA have found that many of the doctors presumably included in the committee's study are dedicated physicians working in isolation in slum and rural areas who are being overwhelmed by a tide of sick humanity . . .

"It would be unfortunate if the committee's report leads the public to believe that medicare and medicaid are riddled with fraud or that the number of physicians abusing the programs is large. Such is not the case . . ."

The report said that incomplete and partial listings indicated 4,300 individual practitioners plus an additional 900 physician groups each received at least $25,000 from medicare in 1968, including 68 who received $100,000 or more.

The staff report sent to the Senate Committee suggested that hundreds of the payment profiles indicate that the physicians involved might be abusing the program. We found many general practitioners each paid $20,000 or more for laboratory services. In many cases we found what is apparently overvisiting and gang-visiting of patients in hospitals and nursing homes.

The staff believes that the majority of physicians on whom information was gathered provided medically necessary services for which they were entitled to charge and be reimbursed. On the other hand, medicare's payments' structure did little to discourage high fees, and thus may well have contributed to the very substantial payment totals to those same physicians.

About 2,500 cases had been investigated for fraud or abuse during the first three years of medicare. It was emphasized that this was only a minuscule fraction of total medicare transactions. Social Security Commissioner Robert M. Ball said:

"About half of the cases investigated resulted from clerical errors, misunderstandings or honest mistakes by physicians and health services. To January 20, 1970, the SSA had referred the cases of 13 individuals and organizations to the Justice Department with recommendations for criminal prosecution for fraud. Two physicians have been convicted in U. S. district courts and indictments have been returned against another five physicians and one non-physician. Another five had been referred with recommendations that civil proceedings be started for the return of illegally collected funds. Early this year, social security investigators also were preparing an additional 35 possible fraud cases for referral to the Justice Department."

The most common types of alleged violations reported include physicians and providers billing for services not rendered, excessive charges, alteration of bills, duplicate billing, misrepresentation of types of services or dates of services, unreported discounts, or kickbacks, and employee embezzlement, medicare officials said.

The report's recommendations were aimed at providing "bases for remedying the serious, costly, and pervasive problems" of the two programs and make them "work more efficiently and economically." However, it was asserted that physicians constitute the cardinal factor.

"The key to making the present system workable and acceptable is the physician and his medical society," the committee staff said. "We are persuaded that at this point in time neither the government nor its agents have the capacity to effectively audit medical practice to assure that a given physician functions responsibly in dealing with the publicly financed programs.

"While there is growing awareness among many physicians of the need for the profession to effectively police and discipline itself, performance has been spotty and isolated so far. Prompt action is necessary by organized medicine (and other health professions) to do what is required with respect to monitoring care provided and charges made for the care . . .

"However, procedures which involve peer review should not be undertaken without precise spelling out and assurances that such review will be comprehensive and effective—not paper and token."

Report Recommendations

(1) Fee schedules for physicians' services.

(2) Generic prescribing of drugs.

(3) Require prior professional approval of elective procedures and expensive courses of treatment.

(4) Require the patient to name a "primary physician" to end "costly 'doctor shopping'."

(5) Require states to provide medicaid recipients with statements outlining payments made in their behalf.

(6) Prohibit independent collection and discount agencies from collecting medicaid or medicare due bills that providers have sold to them.

(7) Establish a medicaid fraud and abuse unit in HEW, and require states to establish similar units.

The American Medical Association urged changes in proposed federal regulations concerning fraud under the medicaid program.

"While we do not condone in any way any fraudulent conduct of physicians in medicaid or in any professional activity, we do believe that physicians will consider the new requirements an unwarranted affront to their integrity in their participation in the program," Dr. Ernest B. Howard, executive vice president of the AMA, said in a letter to the administrator of the medicaid program.

One of the proposed regulations would require physicians to sign form statements certifying that their claims were correct and that they understood fraud could subject them to prosecution.

These statements, Dr. Howard said, would serve no useful purpose because physicians already know that false claims could lead to prosecution. On the other hand the regulation would be "regarded as offensive by many physicians since it obviously impugns their integrity," the AMA letter said.

The other proposed regulation would require state agencies to promptly report suspected cases of fraud.

"It is obvious that serious prejudice may result to a physician where the suspicion of fraud is publicized," the AMA added. "Even when the fraud is not later established, irreparable harm to the reputation of the physician will still have resulted . . . We believe it will be better procedure not to report each suspected case, but to include in the report only those situations where the case has been concluded and fraud has been established."

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

March 15, 1970

A regular meeting of the Board of Trustees was held on March 15, 1970 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Presidential Appointments . . . Approved President Bertha's appointment of the following: James A. Rogers, M.D. of East Orange as MSNJ representative on the Medical Education Facilities Committee of the Comprehensive Health Planning Agency; George E. Barbour, M.D. of Somerville (Jesse McCall, M.D. of Newton, alternate) as MSNJ representative on the Advisory Council to the New Jersey Board of Nursing; and Warren Crane, M.D. of Trenton (Joshua N. Zimskind, M.D. of Trenton, alternate) as MSNJ delegate to the Decennial Meeting of the United State Pharmacopeial Convention.

New Jersey Regional Medical Program Seminar . . . Agreed to endorse the seminar sponsored by the New Jersey Regional Medical Program—Workshop on Hospital Library Service—to be held April 22 at the New Jersey Hospital Association headquarters in Princeton.

Emergency Medical Care . . . Approved (as amended) the following recommendations of the Committee on Emergency Medical Care:

1. That The Medical Society of New Jersey record itself as urging the continuation of medical self-help training courses in the high schools of New Jersey, and that the Department of Education of New Jersey be requested to include the program as a mandatory curriculum item for all New Jersey high schools.

2. That The Medical Society of New Jersey urge the New Jersey Department of Transportation to place *adequate and sufficient* road signs on major highways and thoroughfares indicating the locations and names of nearby hospitals. (Italics indicate amendment by the Board)

3. That the personnel in the toll booths along the various toll highways be prepared to instruct inquiring motorists as to the location of nearby hospitals.

4. That The Medical Society of New Jersey endorse the principle of mobile coronary care units and urge the component societies to contact the various hospitals within their locale concerning *the practicability of* such programs. (Italics indicate amendment by the Board.

Maternal and Infant Welfare . . . Approved (as amended) the following recommendations of the Committee on Maternal and Infant Welfare:

1. That The Medical Society of New Jersey urge all member physicians to perform cytologic smear at least annually on all their women patients *where indicated.* (Italics indicate amendment by the Board)

2. That all women on the contraceptive pill be seen by their physician every six months, as indeed all female patients should be.

3. That no prescription for oral contraceptives be written for longer than a six-month period.

4. That The Medical Society of New Jersey urge the New Jersey Pharmaceutical Association to call upon all its members not to refill prescriptions for oral contraceptives for longer than a total period of six months, except on the specific direction of the patient's physician.

5. That the Special Committee on Maternal and Infant Welfare of The Medical Society of New Jersey nominate an outstanding physician for appointment by the State Department of Health as Principal Field Physician, to investigate and submit reports to this Committee on maternal deaths throughout the State, and that the compensation for this service be set at an agreed upon per diem plus expenses.

6. That if the volume of deaths to be investigated and reported in the view of the designated field physician proves excessive, he be authorized to designate a deputy to assist him in his work.

Pension Plan Trust Agreement . . . Approved the following recommendation and resolutions from the Committee on Pension Plan:

1. That the following resolution be approved adopting Amendment No. 1 of The Medical Society of New Jersey's Pension Trust Agreement, and that the proper officers of the Society be authorized to take the necessary action to make this Amendment effective as of 1 June 1970:

RESOLVED THAT Amendment No. 1 to The Medical Society of New Jersey's Pension Trust Agreement, substantially in the form presented to this meeting, is hereby adopted, and the proper officers are hereby

authorized and directed to do everything necessary or advisable with respect thereto in order to put said Amendment into full force and effect.

2. RESOLVED THAT We, the Trustees of The Medical Society of New Jersey, hereby direct First Trenton National Bank, Trustee for The Medical Society of New Jersey's Employees' Pension Trust Agreement dated 13 July 1955, to surrender all of the life insurance policies held by the Trustee for the cash surrender value effective 31 May 1970.

Retirement Plan for Physicians . . . Approved the following recommendations of the Committee on Retirement Plan for Physicians:

1. That the Board of Trustees formally adopt as a retirement plan for MSNJ members the programs of the Prudential Insurance Company of America, to be administered by E. & W. Blanksteen Agency, Inc.

2. That the Board appoint Richard R. Chamberlain, M.D., Nicholas E. Marchione, M.D., and Albert F. Moriconi, M.D., to serve The Medical Society of New Jersey's retirement plan trusts as Trustees, and to take such steps as are necessary and proper for the formal establishment of this retirement program so that it will be available to the members.

3. That when the documents are sent in for execution by the designated Trustees they be referred to MSNJ's Legal Counsel for review and opinion.

General Session . . . Agreed that the topic for the General Session at the 1970 Annual Meeting would be "Medicaid in New Jersey," to be discussed by a panel composed of representatives of the Department of Institutions and Agencies, Prudential, and the Social Security Administration. The Deans of the two New Jersey Medical Schools will be invited to address the House of Delegates at the opening session, at the time they accept the AMA-ERF presentations in behalf of their schools.

AMA Annual Meeting . . . Authorized the following to attend (with expenses paid) the AMA Annual Meeting in Chicago June 21 to 25, 1970: President, President-Elect, Executive Director, seven delegates, and six alternate delegates.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during March 1970:

	1970 March	1969 March
Aseptic meningitis	3	14
Primary encephalitis	2	2
Hepatitis: Total	178	166
Infectious	158	131
Serum	20	35
Malaria: Total	6	15
Military	5	14
Civilian	1	1
Meningococcal meningitis	9	17
Mumps	227	294
German measles	253	136
Measles	319	108
Salmonella	21	34
Shigella	12	8

Gonorrhea in New Jersey

Gonorrhea has become a major health problem in New Jersey, as well as in the rest of the nation. We have witnessed a rapid escalation in the number of cases of gonorrhea reported in New Jersey especially over the past five years. In fiscal year 1969, more than 8700 cases were reported with a case rate of 125 per hundred thousand. In fiscal year 1965, only 3800 cases were reported, which means we have had a two-fold increase in five years. In 1969, the reported cases included some 2300 from private sources and 6500 from the public clinic sources, a ratio of about 1 to 3. There is a preponderance of male over female patients, and there is a disturbing disproportion of cases in the young adult and adolescent age groups. Reporting is very incomplete, in fact misleading, as far as the total numbers go. However, it is a valid, if unhappy, indication of the trend.

The extent of our statistical deficiency is suggested by recent studies of the American

VISIT THE EXHIBITS

204th Annual Meeting May 16-19

Social Health Association. Their findings reverse the ratio of public to private cases obtained from considering only the reported cases, which are largely clinic derived. By projecting estimates of under-reporting by physicians, it would seem that private physicians are seeing perhaps three quarters of the total number of cases treated in the United States, although they are reporting only 10 per cent (6 per cent in New Jersey). These figures suggest the order of magnitude with which we are dealing. If the 2300 cases reported from private sources in 1969 represent about 6 per cent of those actually seen, the true number of cases of gonorrhea in New Jersey is probably in excess of 50,000. This coincides with experience that the great majority of cases are not reported, and that the 8700 case total mentioned is merely the visible portion of an iceberg, the great submerged bulk of which represents the vast number of unreported cases.

These are treated cases and do not include asymptomatic patients, primarily women. Some investigators believe the asymptomatic state occurs in men as well. When routine cervical cultures are done and plated on a selective medium as many as 10 per cent of asymptomatic female patients have been found to harbor the gonococcus.

The age of distribution of patients is a matter of great concern. Over half of the cases reported are in patients in the adolescent and young adult group. Patients between 15 and 19 years of age, who constituted only 12 per cent of the case load in 1965, represented 20 per cent of the case load in 1969. The proportions of other age groups involved have remained relatively stable.

Accurate information as to the scope of the problem would be of great help in organizing an effective control. Other immediate advantages may also accrue. For example, in July 1968, the New Jersey Legislature, recognizing the increasing number of young patients and minors with gonorrhea, passed a law permitting treatment of minors with venereal disease without parental consent. New Jersey is one of the few states with such a law. This has greatly simplified the therapy of such patients.

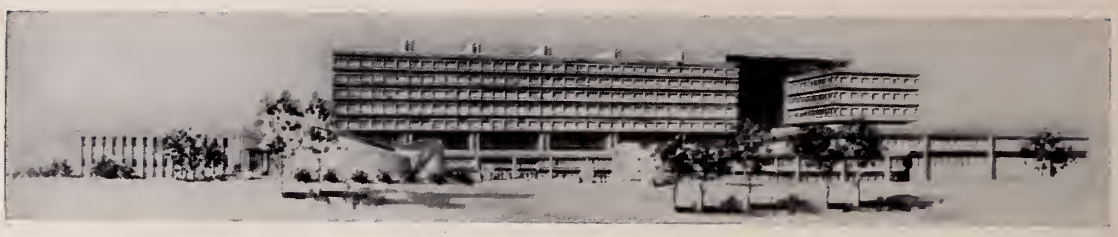
There is, at present, excellent therapy for both syphilis and gonorrhea, despite the relative antibiotic resistance that some strains of the gonococcus have exhibited. Syphilis is better understood as a disease, and we are aided in its control by excellent serologic diagnostic methods. For the near future, routine cervical cultures on a selective medium to detect the asymptomatic reservoir hold the most promise for control of gonorrhea. The eventual control of gonorrhea will certainly require new approaches and considerably more effort than is currently being expended.

Newark Surgeon Chosen "Woman of the Year"

Dr. Christine E. Haycock, Newark surgeon, was accoladed as "Woman of the Year" by The New Jersey Medical Women's Association at a dinner, April 8, 1970.

Dr. Haycock, assistant professor of surgery at New Jersey College of Medicine and Dentistry (and Director of emergency services at The Martland Hospital), is one of the youngest woman doctors to receive this honor. Selections are made on the basis of full-career achievement and service to the community.

Dr. Haycock began her career as a registered nurse, after training at the Presbyterian Hospital School of Nursing in Newark. Graduating from the New York Downstate Medical Center, she became the Army's first woman intern at Walter Reed Army Hospital in Washington, D.C. She served one year in Japan with the Army during the Korean War. She finished her surgical residency at St. Barnabas Hospital in Livingston, and St. John's Episcopal Hospital in Brooklyn, setting up practice in Newark in 1959. She is a diplomate of the American Board of Surgery.



News From NJCMD

The faculty of your medical institution continues to grow. Well-known physicians who have recently joined NJCMD include:

John T. Mallams M.D., named Professor of Radiology and the first Chairman of the Department of Radiology. Dr. Mallams, who plans to locate in East Orange, has been Professor of Clinical Radiology at Yale University School of Medicine and Attending Radiologist at Yale-New Haven Hospital. A diplomate of the American Board of Radiology, he is a member of the American Roentgen Ray Society, American Radium Society, and Radiological Society of North America. Dr. Mallam is also a member of the Society of Nuclear Medicine, American Association for Cancer Research, and New York Academy of Science. In 1967, the Angiology Research Society awarded him its Honor Achievement Award.

Ralph R. Goldenberg M.D., widely known orthopedic surgeon, has been named Director of the Division of Orthopedic Surgery at NJCMD. Formerly Associate Professor of Clinical Orthopedic Surgery at New York University, Dr. Goldenberg is associated with St. Joseph Hospital in Paterson, and also with the Valley Hospital in Ridgewood; Alexander Linn Hospital in Sussex; Chilton Memorial Hospital in Pompton Plains; and Good Samaritan Hospital of Suffern, New York. A Fellow of the American Academy of Orthopedic Surgeons, Dr. Goldenberg is a member of the American College of Physicians, both the American and Canadian Orthopedic Associations, and the Orthopedic Research Society. In 1951 he served as President of the New Jersey Orthopedic Society; Associate Editor of the *Journal of Bone and Joint Surgery* in 1964; and Chairman, Orthopedic Section, of the New York Academy of Medicine in 1954.

The new Acting Chief of the Division of Anesthesiology is Associate Professor Benjamin M. Rigor, Sr., M.D. He was formerly Assistant Professor in the Department of Anesthesiology at the University of Kentucky College of Medicine. The author of many papers and projects, Dr. Rigor is a Fellow of the American College of Anesthesiology, and a member of the American Society of Anesthesiologists.

Help Us "Spread The Word"

A number of doctors have inquired how they (and the communities which they serve) can learn more about the many activities in which the College finds itself involved. This is gratifying, and we are delighted to be able to offer several ways in which the NJCMD story can be presented.

With regard to the profession, we are anxious to supplement these articles with other contacts. The College has several forms of display material as well as literature and other informative aids. One is a three-dimensional architectural model of our proposed Newark campus, which has received enthusiastic welcome wherever it has been shown. This 7′ x 9′ model comes with its own base and the College can set it up and remove it after the agreed exhibit period.

We have pictorial displays of the plans for the new buildings, detailing the various units which comprise the campus, and showing the needs involved in medical training and how those needs are reflected in the college curriculum and the physical layout of buildings, laboratories, library, hospital areas, and various support facilities.

Reflecting some of the specific programs in which your college is moving, we also have a special photo exhibit depicting our Cardiac Ambulance program (February 1970 *Journal*, MSNJ) and are preparing additional display material on the New Jersey Division of Drug Abuse (March 1970 *Journal*, MSNJ).

We hope to have all our visual exhibits at the May round of meetings to be held in Atlantic City: scientific, medical, dental, and health.

We will be delighted to make display material available for your component society meetings, and will very much appreciate your suggestions regarding other opportunities to acquaint the people of New Jersey with the plans of their College of Medicine and Dentistry, the only four-year medical school in the state.

Support from physicians will be most helpful, as they are recognized as leaders in prominent civic and public affairs. Many are active in civic organizations, service clubs, church groups, fraternal lodges, and so on. Your help in letting us know of suitable meetings, display areas with high exposure, and the like will be of immense aid. Please address any suggestions, comments, or questions to: Lee R. Munsick, Director of Professional Relations, NJCMD, 100 Bergen Street, Newark, 07103.

Drug Abuse

Initial response to the article on our Division of Drug Abuse has been gratifying. Booklets are available for public distribution through your group, for placement in your waiting room, or for mailings. Sample copies of this literature and "The Promise," which describes the College and its Newark campus plans, are still available at the address above.

A Medical Scholarship For Your County?

(Submitted by Maurice B. Gordon, M.D., 6917 Atlantic Avenue, Ventnor)

There was recently established the Benjamin Lee Gordon Memorial Scholarship in memory of my late parents. This includes a $5,000 award to one Atlantic County resident on the basis of a combination of financial need and academic merit, to enable the recipient to attend medical school. It is an outright gift, divided into four yearly stipends.

The Dr. and Mrs. Benjamin Lee Gordon Memorial Scholarship is administered and awarded by the Atlantic County Medical Society through a special tax-exempt charitable corporation acceptable to the Internal Revenue Service—the Atlantic County Medical Society Scholarship Fund.

County medical scholarships of this type do not supersede the wonderful work being done by the AMA-EMF and other national organizations. They rather constitute an effort to round out the medical scholarship picture on a local level.

I am seeking 199 other physicians, who have raised their own children, but still are deriving excellent incomes from their practices, and who would like to establish $5,000 scholarships controlled by their county medical societies, and thus help children of less fortunate area residents become physicians.

The first scholarship in this program was donated by the husband-wife team of Anderson Nettleship, M.D. and Mae Banwell Nettleship, M.D. The award went to Nicholas P. Lang, a freshman medical student at the University of Arkansas, through the Washington County Medical Society in Fayetteville, Arkansas.

I would deem it an honor to award a "Certificate of Meritorious Service to the Future of Medicine in America" to each donor. The success of this venture would allocate physician-earned dollars for the future medical needs of society.

Stamp Album Honors Physicians

Medical achievements from the ancient world to the present day have been graphically portrayed on the stamps of many nations. Now, a special album, *Medicine on Stamps,* has just been published which presents the highlights of medical progress. It was written by Joseph H. Kler, M.D. of New Brunswick. The album is based on Dr. Kler's priceless 44 volume collection which includes over 16,000 stamps related to medicine. In fact, the book is both a text and a stamp album, in which one can mount the stamps illustrated on each page. The pages are loose-leaf in a ring binder, which accommodates supplementary pages as new stamps honoring the heroes of medical science are issued. Beneath each illustration in the album is a capsule biography of the physician or medical scientist shown on the stamp. The men of medicine span the centuries from Imhotep, the most celebrated physician of ancient Egypt, to the Mayo Brothers.

The commentary in the album contains many attention-arresting sidelights on the history of medicine, such as the fact that Pope John XXI in the 13th century was a physician, as was Georges Clemenceau, the Prime Minister of France during World War 1, and Sun Yat-sen, the first President of China. Each of these is commemorated on stamps and space is provided in the album for the appropriate issues. Illustrations of stamps from many nations representing diverse fields of medicine also are included, such as: ophthalmology, anesthesiology, bacteriology, pathology, neurology, and public health.

Medicine on Stamps is a way you can reacquaint yourself with the history of medicine, and introduce yourself to the pleasures of stamp collecting. This album also is an attractive way to introduce children to the outstanding record of medical progress and to the possibilities open to them in the medical profession. It is published by Minkus Publications, Inc., 116 West 32nd Street, New York 10001. The price is $10.

Examinations In Family Practice

Two thousand family doctors took the written examination early in March to qualify them as specialists in family practice, the new medical specialty emphasizing comprehensive, continuing care of the family. The examination was offered at 36 centers throughout the United States under the aegis of the American Board of Family Practice. The test was devised with the cooperation of the National Board of Medical Examiners, and administered by Science Research Associates of Chicago. Not a single one of the 36 examination sites was in New Jersey.

The examination marks a milestone in American medical history, bringing medical education almost full circle. Before World War II most doctors were general practitioners and patient-care oriented. Since the war, emphasis has been on specialization to the extent that fewer than 15 per cent of medical school graduates enter family or general practice today.

The doctors who took the examination in March were veteran family physicians who have called themselves, variously, family doctors, family practitioners, general practitioners, or generalists. Each has been in practice at least six years, or has been a medical school teacher at least six years, or has had a residency in a special field but still chose to enter family practice. Most are members of the American Academy of General Practice. The Academy requires its members to take graduate study. Members must complete at least 150 hours of approved study during the three-year tenure of membership. One of the qualifications for taking the examination in March 1970 was satisfactory completion of 300 hours of approved study.

These 2,000 doctors, and later "practice eligible" candidates for certification in family practice, are the vanguard of a new type of highly competent "people doctor" whose numbers will swell as medical centers and teaching hospitals begin turning out resi-

dency-qualified family specialists in quantity. They will not only have proved their ability in the field of comprehensive, continuing care of the family, but also will have agreed to recertification after six years. No other specialty requires its diplomates to prove their competence on a continuing basis.

Rubella Vaccine Now Available

Smith Kline and French Laboratories have rubella vaccine. The manufacturers say that compared with other rubella vaccines, Cendevax has been found to cause fewer and less severe arthritis-like side effects in adult women. It is the most widely tested rubella vaccine, with clinical studies conducted in 17 countries. Over 98 per cent effectiveness was shown in studies involving more than 85,000 children and adults in the United States.

The license to distribute Cendevax was granted by the U.S. Secretary of Health, Education, and Welfare to SKF's Belgian subsidiary (Recherche Therapeutique) which manufactures the vaccine at new facilities capable of producing about 35 million doses per year.

Studies have shown that the vaccine is safe and does not spread to susceptible subjects kept in close contact with the vaccinees.

The most recent epidemic of German measles in the United States occurred in 1964-65. Its tragic consequences were an estimated 20,000 birth abnormalities and 30,000 fetal deaths. The cycle of the disease indicates another epidemic may begin in 1970. Total cost to the country of rehabilitating the rubella-damaged children from the 1964 epidemic has been estimated to be over $1.5 billion.

Statistically, 20 per cent of women of childbearing age are susceptible to rubella. However, tests have uncovered pockets of unusually high susceptibility in women between ages 18 and 35. In these tests, susceptibility was discovered to range from 25 per cent to 56 per cent among women of childbearing age.

Smith Kline and French finds that adverse reactions to Cendevax in children have been rare and generally confined to very mild rubella-like symptoms, such as slight swelling of lymph nodes, low-grade fever, or rash. Adult women have also developed infrequent, mild rubella-like symptoms and in addition have sometimes experienced transient arthralgia and more rarely arthritis. Such joint symptoms in women are, says the manufacturer, less common, milder, and of shorter duration with Cendevax than those reported with other rubella vaccines.

Mary Mazzarella, President of New Jersey Medical Women's Association

Mary T. Mazzarella, M.D., a member of The Medical Society of New Jersey and Assistant Medical Director of Schering Laboratories, has been installed as President of the New Jersey Medical Women's Association. This organization, the New Jersey branch of the American Medical Women's Association, seeks to promote interests common to women physicians and the public; to provide financial aid and encouragement to women pre-medical, medical, and graduate medical students; and to foster constructive movements in public health and relief work.

Born in Newark, Dr. Mazzarella received her B.S. degree from the College of St. Elizabeth, and her M.D. degree from the University of Rome Medical School. She completed a pediatric residency at Babies' Hospital in Newark, and prior to joining Schering in 1965, had a private practice in pediatrics.

ANNOUNCEMENTS

Symposium On Sexuality

Members of The Medical Society of New Jersey are invited to attend an all-day session on Human Sexuality at the State College in Upper Montclair on Wednesday, June 17. This symposium will begin at 9:30 a.m. The Essex County Medical Society is cosponsoring the colloquium, together with the Educational Foundation for Human Sexuality. For a detailed program, write to Allan B. Crunden, Jr., M.D. at 26 Harrison Avenue, Montclair, New Jersey 07042.

Otolaryngology For The GP

Miami in November is a fine place for a graduate seminar in laryngology and otology. A program is now available for November 13 and 14 in the form of a graduate course for family practitioners. It is accredited by the AAGP. For more details, air-mail a letter to F. W. Pullen, M.D., Otologic Laboratory, School of Medicine, University of Miami, Box 875, Biscayne Annex, Miami, Florida 33152.

Cryosurgery in EENT

Ophthalmologists and otolaryngologists are invited to a luncheon seminar on cryosurgical procedures in EENT on Sunday, October 4 at the Dunes Hotel, Las Vegas, immediately preceding the convention of the American Academy of Ophthalmology and Otolaryngology. A top-notch faculty has been assembled. For further information, write to the Society of Cryosurgery, 3 North Michigan Avenue, Chicago, Illinois.

Ob-Gyn Seminar in Florida

The place is right—Florida. The month is right—November. The University of Florida announces a seminar in gynecology and obstetrics to be held November 19 and 20 at Gainesville. The faculty is a team of obstetricians and gynecologists whose names are recognized throughout the specialty. For more details, write to Division of Graduate Education, Box 758, University of Florida College of Medicine, Gainesville, Florida 32601.

Narcotics Film Available

Although the "hip generation" is at last becoming disillusioned with hard drugs and marijuana, the curiosity and search for "kicks" are still prevalent among high school and college students who feel they are not "with it" unless they swing at least on one trip. Consequently, education and straight talk about the hazards of drug abuse are still essential.

The National Association of Blue Shield Plans, 211 East Chicago Avenue, Chicago, Ill., 60611, has now completed the third of its trilogy of motion pictures for showing by medical societies and related groups to students and community organizations. This final film, *Bridge From Noplace*, is equally suitable for television. Narrated by Academy Award winner Rod Steiger, it reports on innovations now being tried by rehabilitation centers throughout the U.S.A. This motion picture, plus the three-part package under the series name of "The Distant Drummer," may be requested from our New Jersey Blue Shield Plans or the national office.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

May

12 **Associated Eye Residencies**
(Newark Eye and Ear Infirmary, Jersey City Medical Center, Martland Medical Center, VA Hospital
Newark Eye and Ear Infirmary
"Dylexia"

12 **Bergen County Medical Society**

13 **Ocean County Medical Society**

13 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

14 **Burlington County Memorial Hospital**
Mount Holly
Surgical Management of Heart Disease and Selection of Patients for Heart Transplant

16-19 **The Medical Society of New Jersey**
Chalfonte-Haddon Hall
Atlantic City
Annual Meeting

17 **Clara Maass Hospital**
Department of Neuropsychiatry
Belleville
"Anxiety"

19 **New Jersey Society of Anesthesiologists**
Holiday Inn
Kenilworth

21 **Burlington County Memorial Hospital**
Mount Holly
Diagnosis and Management of Pulmonary Embolic Disease

21 **Gloucester County Medical Society**

21 **Morris County Medical Society**

25 **Cape May County Medical Society**

27 **Academy of Medicine of New Jersey**
Mayfair Farms
West Orange
Annual Awards Dinner

27 **Middlesex County Medical Society**

28 **Academy of Medicine of New Jersey**
Radiology Section
Bloomfield
Interesting X-rays of the Month

June

3 **New Jersey Gastroenterological Society**
Holiday Inn
East Orange
Symposium on Liver Disease

6 **Radiologic Society of New Jersey**
Berkeley-Carteret Hotel
Asbury Park
Semi-annual Meeting

9 **Bergen County Medical Society**

9 **Cumberland County Medical Society**

10 **Middlesex County Medical Society**

10 **Ocean County Medical Society**

10 **Tuberculosis-Respiratory Disease Association of Southern New Jersey**

July

16 **Warren County Medical Society**

18 **Morris County Medical Society**

19 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

17 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

21 **Monmouth Medical Center**
Long Branch
Visiting Professor Conference in Pediatrics

Letters To The Journal

Not All Greek To Us

March 13, 1970

Dear Doctor:

I enjoyed reading the above article ("Fading Imagery of Medical Words," Vol. 67, No. 3), because it reminded me of similar experiences in my native Greece. Of course, there, we understood "egophony" perfectly, because even the city-slickers of us had seen and heard a goat—but what about the sago spleen? Our pathology book had to have a footnote, explaining that sago is a common thing in Germany, but not in Greece. And our professor, we found out, had never seen a nutmeg (until a colleague brought one to the lab one time) although he had seen (and taught us about) many "nutmeg livers." And always an explanation for the "porphyry spleen" was needed, even in the land of marbles. On the other hand, we city slickers knew about "ham spleen." "Phrygian cap," of course, was familiar from ancient history, as well as winepress, stapes, saddles, even sabers. But I have to confess that I never before heard of "trolley-eye" or "Duckbill speculum."

Perhaps it is interesting to compare things that are familiar to one group of people (or nations) and unfamiliar to others. Our anatomical book said that the kidneys have the shape of beans; on the other hand, here we talk about "kidney beans." (Obviously, kidneys are more than beans, here!)

About the anatomic snuff box, we were told that it does not resemble a real snuff box, but it was the only convenient place for an anatomist (with soiled hands) to have his snuff, during a dissection.

Oh, old anatomists and pathologists had an imagination and literary qualities as well. What about the "Psalter of David," or "the quill," or "Ammon's horn?"

A little consolation for non-Greek natives: there is no word for "toe" in Greek; one speaks of "finger of foot!"

(signed) Constantine H. Makris, M.D.

Mace And The Ducking Stool

March 5, 1970

Dear Doctor:

Marty Weinberg's use of Mace in the management of mental hospital patient behavior seems a particularly unimaginative approach. The implied endorsement of Mace as a medical instrument seems a dangerous threat to the image of the medical profession in general and of the specialty of psychiatry in particular. Especially does it seem inappropriate for Mace to be associated with the one New Jersey Hospital dedicated to the image of Dorothea Dix. She must have turned at least once in her grave in this instance.

It seems a specious bit of reasoning to term Mace an instrument of medical treatment. Dr. Weinberg would have come across better if he had said that there are times, in a hospital for the criminally insane, when police security measures must be used with medical restraint.

Must psychiatry add Mace, in the 20th Century, to the iron chains, the ducking stool, the spinning chair, the solitary confinements, and the epidemic of lobotomizing with which the history of the art sparkles in its glorious past attempts to ameliorate the suffering of the mentally afflicted?

(signed) Ira S. Ross, M.D.

OBITUARIES

Dr. Arthur R. Abel

On September 19, 1969, Arthur R. Abel, M.D., a member of the Essex County Medical Society, died at the age of 72. Dr. Abel earned his M.D. at the University of Nebraska Medical School in 1925. He was a pioneer in the field of pathology and hemotology, and became an early diplomate of the American Board of Pathology. He was affiliated with the Orange Medical Center.

Dr. Benjamin R. Huddel

Benjamin R. Huddel, M.D. of Camden was killed in an automobile accident on March 25, 1970 at the untimely age of 40. Dr. Huddel was a 1961 graduate of the Jefferson Medical College, and was an instructor in psychiatry at his Alma Mater. He was a consultant at the New Jersey State Hospital in Ancora, and a member of the Camden County Medical Society.

Dr. James S. Knowles

One of Camden County's most distinguished citizens, James S. Knowles, M.D., died on March 23 at the age of 81. Dr. Knowles was a general practitioner with long interest and skill in obstetrics. He was an alumnus of the class of 1911 at the old Medical-Chirurgical College in Philadelphia. He served a term as President of the Cumberland County Medical Society. He was a member of the Millville City Council, and a school physician. Dr. Knowles served in both World Wars, and was demobilized as a Lieutenant Colonel in 1945. He was a 1961 recipient of The Medical Society of New Jersey's Golden Merit Award. Dr. Knowles was active on the staff of the Millville Hospital.

Dr. George H. Mueller

Word has just been received from Switzerland of the death of George H. Mueller, M.D. at the age of 83. Dr. Mueller was a Bellevue graduate, class of 1910. At the age of 55, in 1942, he entered the Army of the United States as a Major in the Medical Corps. Dr. Mueller was a surgeon and served the people of Hudson County for a half century. He was a Fellow of the American College of Surgeons, and was a laureate of the Golden Merit Award of MSNJ in 1960. His death occurred in Interlaken, Switzerland on October 13, 1969.

Dr. Anthony J. DeMasi

At the untimely age of 46, Anthony J. DeMasi, M.D., died on March 1, 1970. He received his M.D. at the University of Rome in 1956 and was a general practitioner with special interest in cardiology. Dr. DeMasi was on the staffs of both hospitals in Orange, New Jersey, and had his office in that city.

Dr. Henry C. Schwartz

One of southern New Jersey's best known and best beloved practitioners died on March 12, 1970. Henry C. Schwartz, M.D., was born in 1899, and earned his degree at Jefferson Medical College in 1924. He was the first medical director of the Edgewood Medical Center and played a major role in the development of the southern division of the West Jersey hospital. During World War II, in spite of his age (he was 43 at the time of Pearl Harbor) he volunteered for service and was commissioned a major in the medical corps of the Army of the United States.

204th ANNUAL MEETING

May 16-19, 1970 Atlantic City

BOOK REVIEWS

Micro-Neurosurgery. Robert W. Rand, M.D. St. Louis, 1969, Mosby. Pp. 244. Illustrations 150. ($25)

Man is moving in two directions: to the limitless world of outer space, and into the world of the infinitesimal. In the micro-world, we have seen the development of surgery in the inner ear accomplished through the surgical microscope, and there have evolved other applications of this delicate branch of surgery. Here we have a beautifully illustrated volume to which a handful of experts have made authoritative contributions. The text covers microsurgery in specific neurological areas, such as handling peripheral nerves, dissecting out acoustic tumors, rizotomy, reaching the pituitary, doing microvascular surgery, and so on. There is also valuable material here on the construction and care of the surgical microscope and micro-surgical instruments. There is no book quite like this. It is, of course, a veritable *vade mecum* for neurologists and for surgeons. And it is an interesting and inspiring book for all medical practitioners who want to know about recent advances in any phase of their art, and who can take pride in the beautiful work done by the micro-neurosurgeon.

J. L. Barone, M.D.

Modern Treatment (Vol. 6, #6): **Treatment of Epilepsy and Other Paroxysmal Disorders,** J. Gordon Millichap, M.D., Editor; **Treatment of Hyperlipidemia,** Donald Berkowitz, M.D., Editor. New York, 1969, Hoeber Medical Division, Harper and Row. Pp. 237. ($16 per year, by subscription)

For the last six years, Harper and Row have beer publishing the *Modern Treatment* series, two topics per issue. Frequently, both subjects have been highly specialized and it seems unlikely that the same practitioner will be interested in both. In the present volume, for example, a 57-page section on hyperlipidemia is combined with a 123 page section on epilepsy and other paroxysmal disorders. The material on hyperlipidemia reviews its chemistry, biosynthetic pathways, and related physiologic mechanisms, and concludes with chapters on dietary and drug treatment and on the management of lipid disorders associated with liver disease.

The section on epilepsy is clinically oriented and covers material on the differential diagnosis of, and management of, vertigo, narcolepsy, hyperkinetic behavior febrile convulsions, and the traditional epilepsies, and offers an excellent chapter on electro-encephalography.

William Schram, M.D.

Circulatory and Respiratory Mass Transport. Edited by G. E. W. Wolstenholme and Julie Knight (Ciba Foundation). Boston, 1969, Little, Brown. Pp. 310. Illustrated. ($12.50)

This interdisciplinary symposium comhines physiologists' and physicists' approaches to an understanding of fluid and gas dynamics in the vascular and pulmonary systems. The emphasis is primarily on the microtubular components of these systems with free use of mathematical-physical models. The authors use graphs and diagrams effectively to communicate the complex mathematical material. Guyton's discussion of the evidence favoring a negative interstitial pressure is particularly lucid. This symposium missed a rare opportunity to develop theoretical aspects of active versus passive components of maintaining vascular tone, such as: is vasodilation possibly the active and energy-requiring phase according to physical models? Or, is vasoconstriction the least favored state in mathematical model systems? Factors influencing pressure-flow interrelationships are discussed at some length in the majority of sections and could have been extended to envelop this very important question. I recommend this text to educators and investigators of cardiovascular and respiratory physiology and pharmacology.

William A. Pettinger, M.D.

Ophthalmology (Volume 1), Proceedings of Manhattan Eye, Ear and Throat Hospital. Symposium. Edited by Arnold I. Turtz, M.D. St. Louis, 1969, Mosby. Pp. 311. Illustrations 247. ($27.50)

This meeting brought together a distinguished group of ophthalmologists who presented papers and participated in panel discussions on many topics of current interest. The papers here are grouped into six sections for an orderly presentation of the material. They are (1) new concepts in ocular therapy, (2) controversial areas in ocular surgery, (3) pediatric ophthalmologic pfoblems, (4) ophthalmic plastic surgery, (5) new technics in ophthalmology, and (6) complications in ocular surgery.

The emphasis throughout was on challenging older procedures and thoughts with new approaches to eye disease. Papers on post-traumatic pseudophakia in children, the epikerato-prosthesis, and expandable orbital implants were among those that brought out new ways of handling some important problem areas.

I highly recommend this book for the many ophthalmologists who were not able to attend the symposium and want to profit from all the effort that went into making it an outstanding medical meeting.

Arthur S. Kern, M.D.

Psychotherapists and Children. Florence L. Swanson, M.D. New York, 1970, Pitman Publishing Company. Pp. 145. ($6.50)

Dr. Swanson spent most of her professional life here in New Jersey. She was, for years, director of the Montclair and West Essex Guidance Center. In this book, she offers us a procedural guide. One of the complaints against psychiatric texts in general is the tendency to lay down broad principles and shun specific technics. Dr. Swanson avoids this indictment by actually describing such details as the kind of toys to have available in a clinic waitng room, or the conduct of an initial interview with a child, or how to cope with an emotional outburst, and even how to handle personal questions about the therapist asked by a curious child. There is material on how to terminate therapy, a list of books (with annotations) on child psychotherapy, and a form for recording basic data.

The book is aimed at the physician, the nurse, the psychologist, the social worker, the teacher, and the counselor. It informs but it never talks down to the reader. The style is lucid. It is nontechnical without being oversimplified, and it points out some significant booby-traps on the way to success. So down-to-earth is the approach, that the reader may feel he is looking at, and listening in on, a therapeutic session. And so far as I know, there is no other compact text which quite covers this ground.

Henry A. Davidson, M.D.



Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

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Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

This is the "answering service" your patient takes home with her...



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Helpful booklet saves unnecessary phone calls—Reminds her of your directions concerning her oral contraceptive schedule . . . contains supportive instructions for "Sunday starting" . . . explains in simple language many aspects of "the pill."

Packaging helps her stay on schedule—The Ovulen Compack®, with each tablet designated by day and week of cycle, shows at a glance the last day on which a tablet was taken.

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"the convenient one"

NOTE: For the budget-minded woman specify Triopak™, a three-month supply (1 Compack and 2 Refills).

Actions—Ovulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain and the United States have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives.

The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

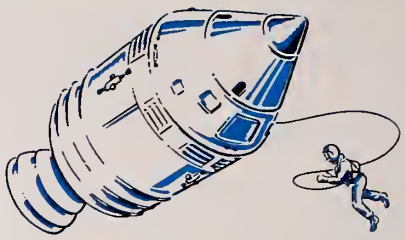
The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651:657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.



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Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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Recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]

Recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilsan, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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TRADEMARK: A V C

AV-919A 7/69

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My in-laws are great.
The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS* EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK* (strip pack). Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

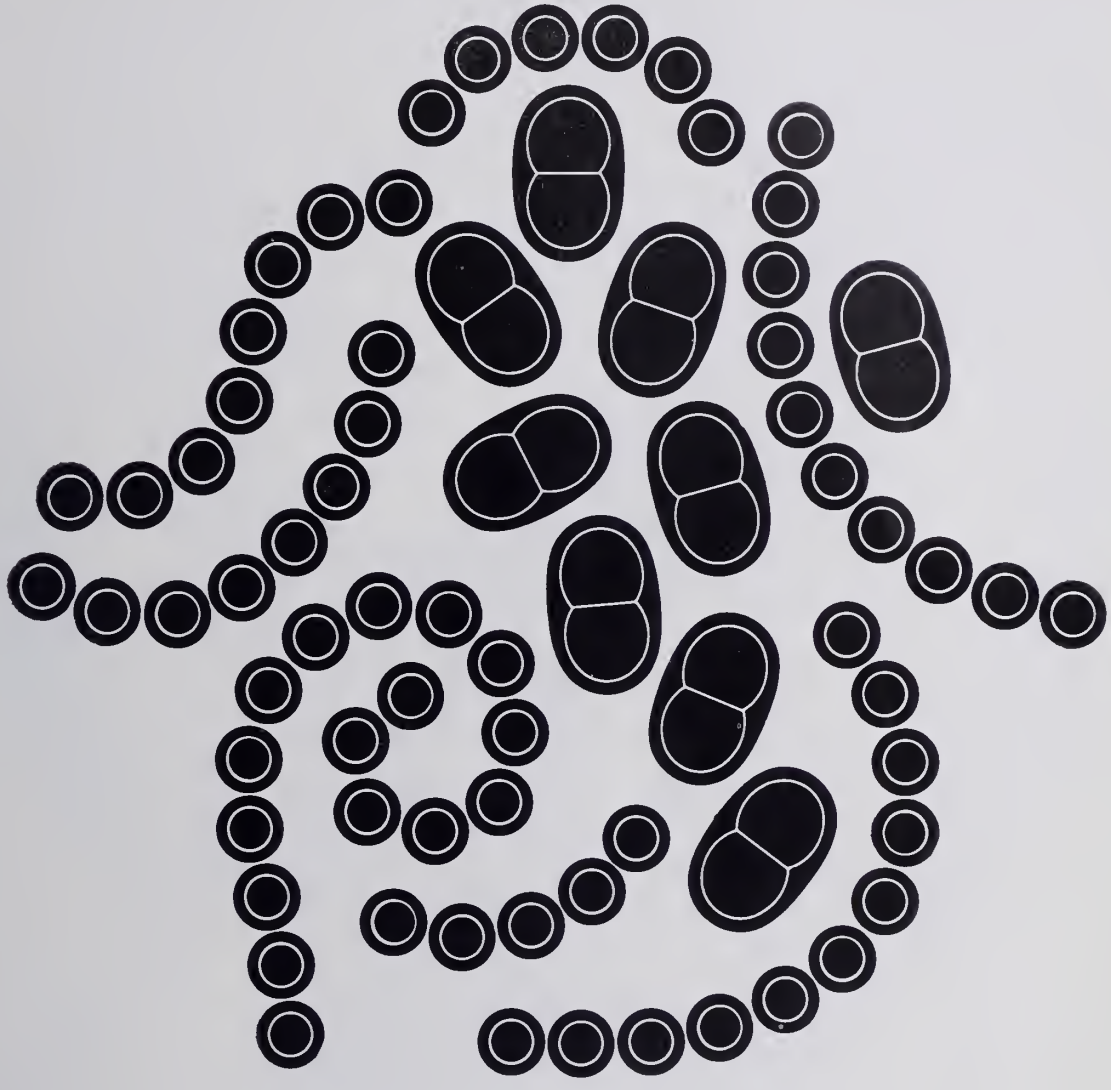
You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

Equanil®
(meprobamate)
Wyeth Laboratories
Philadelphia, Pa.

Photo professionally posed.



during and after infection



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

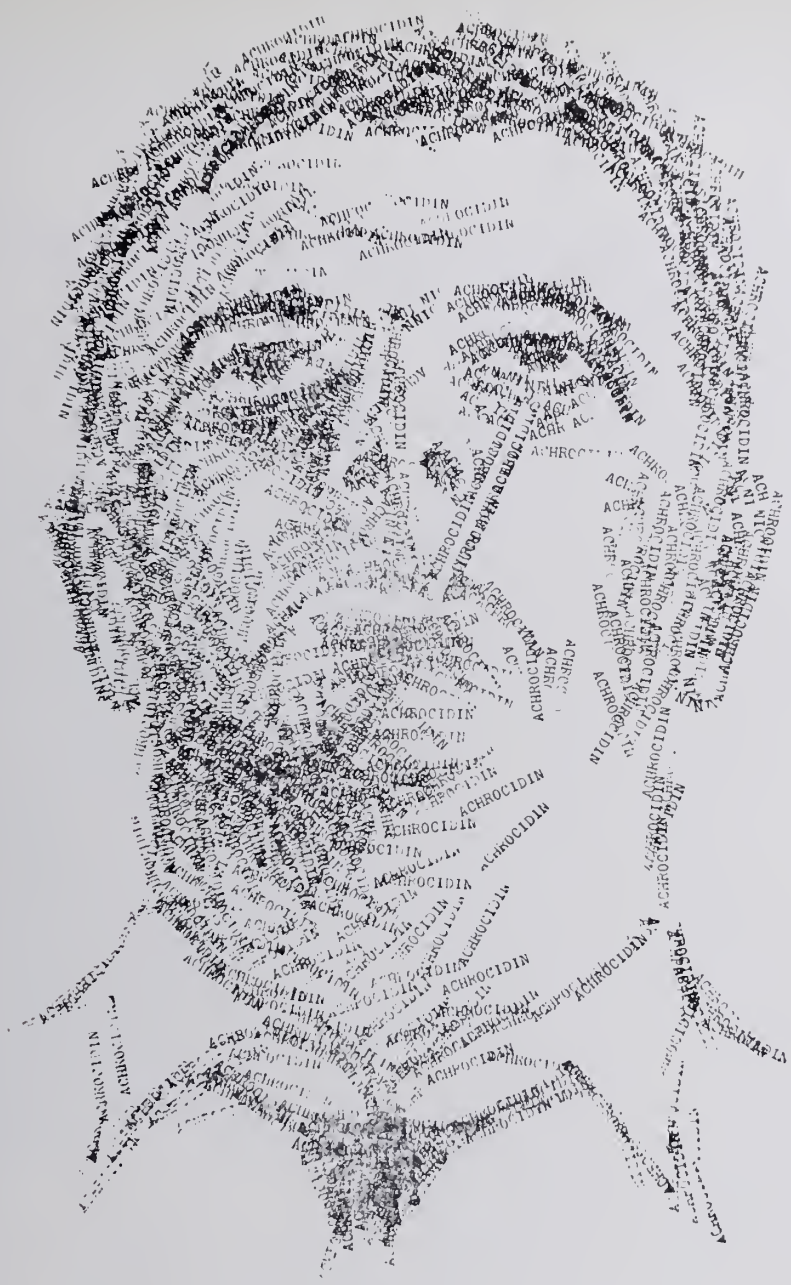
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Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

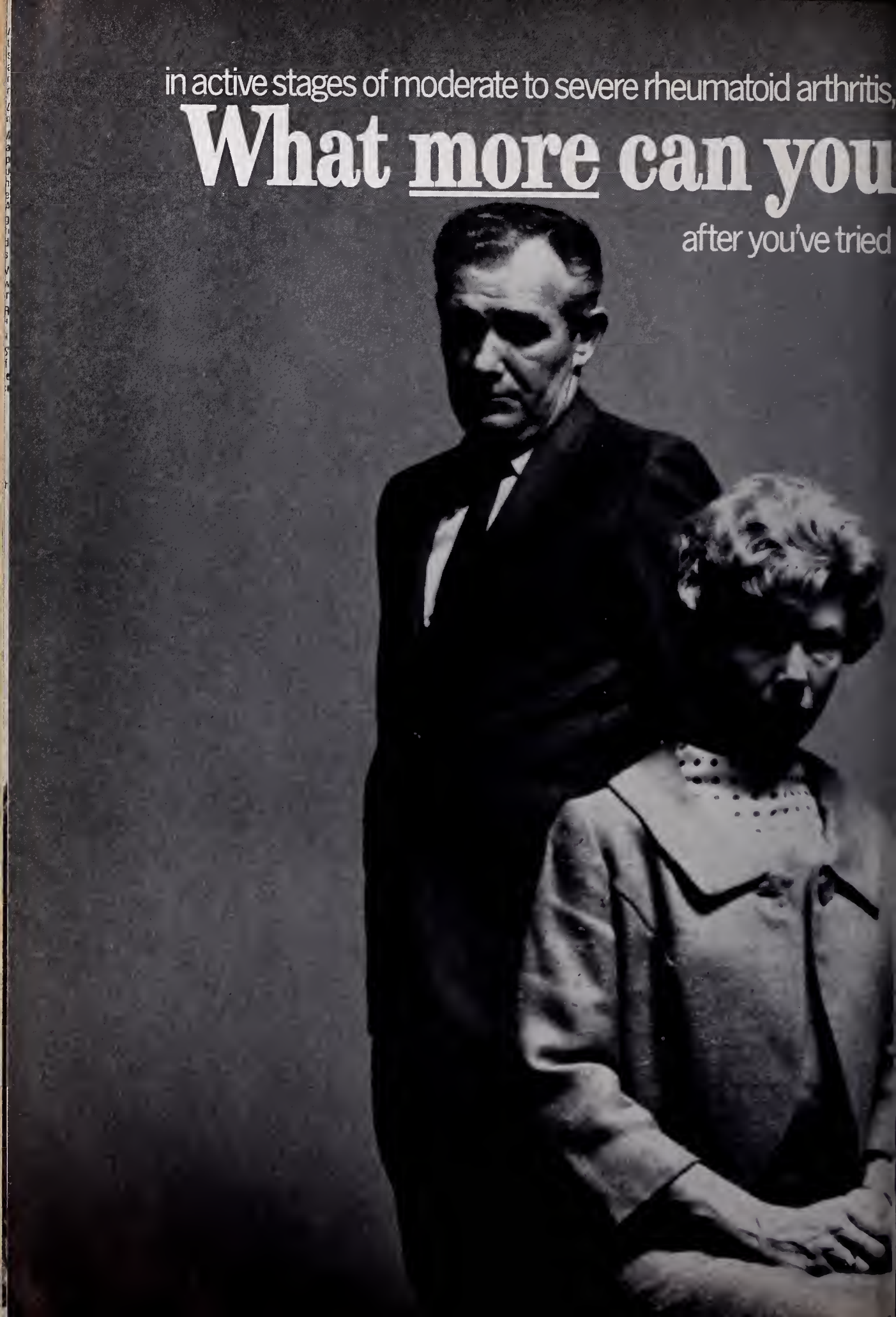
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535-9

in active stages of moderate to severe rheumatoid arthritis,

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do for these patients?

salicylates and rest



INDOCIN®

(INDOMETHACIN | MSD)

helps relieve pain, fever,
swelling, and tenderness

Please see new prescribing information on following page.



REVISED PRESCRIBING INFORMATION

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Indications: Symptomatic relief of adult rheumatoid and degenerative joint disease unresponsive to adequate trial of salicylates and other measures of established value, such as appropriate rest. Has been found effective in active stages of: 1) moderate to severe rheumatoid arthritis including acute flares of chronic disease, 2) moderate to severe rheumatoid (ankylosing) spondylitis, and 3) moderate to severe degenerative joint disease of the hip (osteoarthritis of the hip). Has been found effective in relieving pain and reducing fever, swelling, and tenderness in acute gouty arthritis in selected patients. May enable reduction of steroid dosage in patients receiving steroids for the more severe forms of rheumatoid arthritis; in such instances the steroid dosage should be reduced slowly and the patients followed very closely for any possible adverse effects.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

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Well, Dr. Cunningham! I was just telling Herbert I should talk to you about my allergy. First my nose starts to tickle and..."

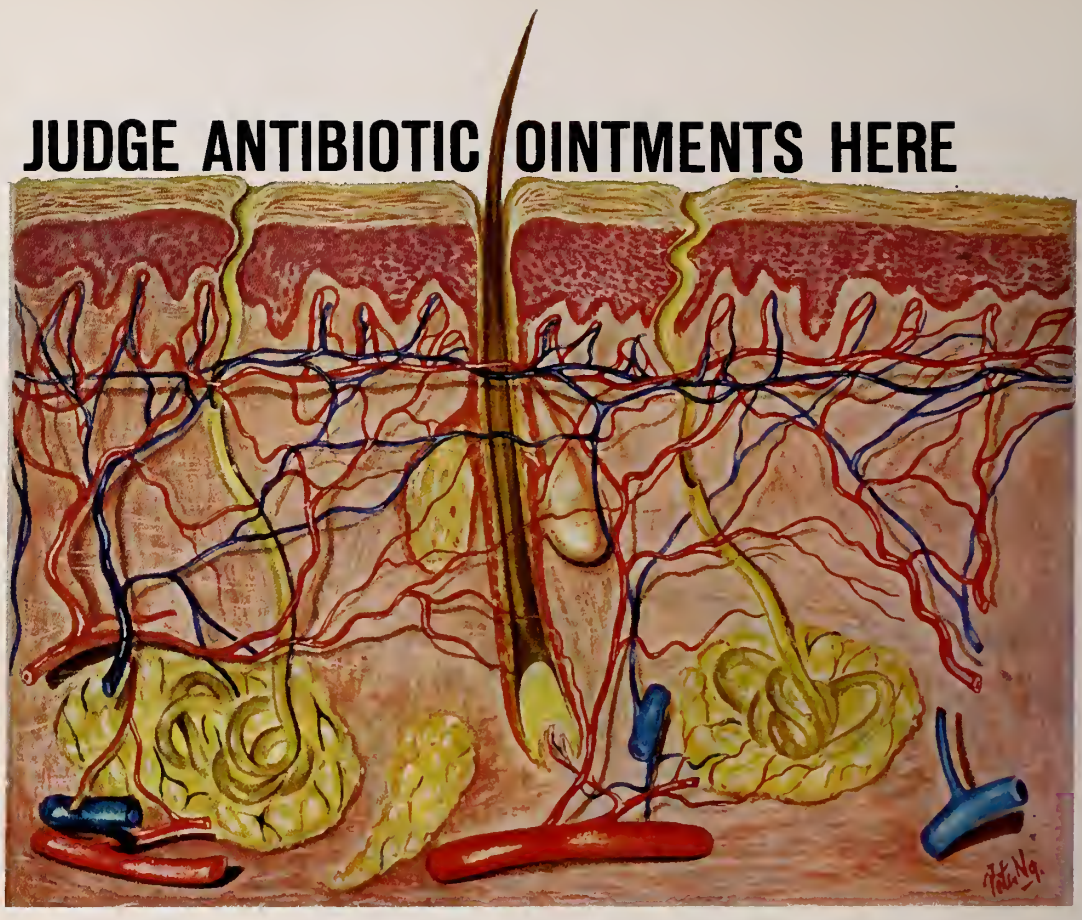
You know the rest of the story. Sneezing. Watery eyes. Nosy nose. And for prompt relief of these symptoms, here's Novahistine® LP. These continuous-release tablets have a vasoconstrictor-antihistamine formulation that begins working in minutes, then continues to provide relief for hours. Even when nasal congestion is due to repeated allergic episodes, two Novahistine LP tablets, morning and evening, let most patients breathe freely all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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optional therapy

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All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

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CAUTION:

OVEREATING MAY BE HAZARDOUS TO YOUR HEALTH.

According to the Framingham Heart Study, the obese face:

86% greater risk of angina pectoris,
82% greater risk of diabetes,
71% greater risk of coronary heart disease.*

Obesity may also aggravate osteoarthritis, flat feet, intertriginous dermatitis, varicose veins, and ventral or diaphragmatic hernias.[1-3]

If you are considering weight reduction, consider

Preludin®
phenmetrazine hydrochloride
Endurets®
prolonged-action tablets

Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

Long acting

Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

Once-a-day dosage

One Endurets tablet after breakfast. It helps reduce weight and costs, conveniently.

For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by mid-morning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.
(B)R3-46-560-B

For complete details, please see full prescribing information.

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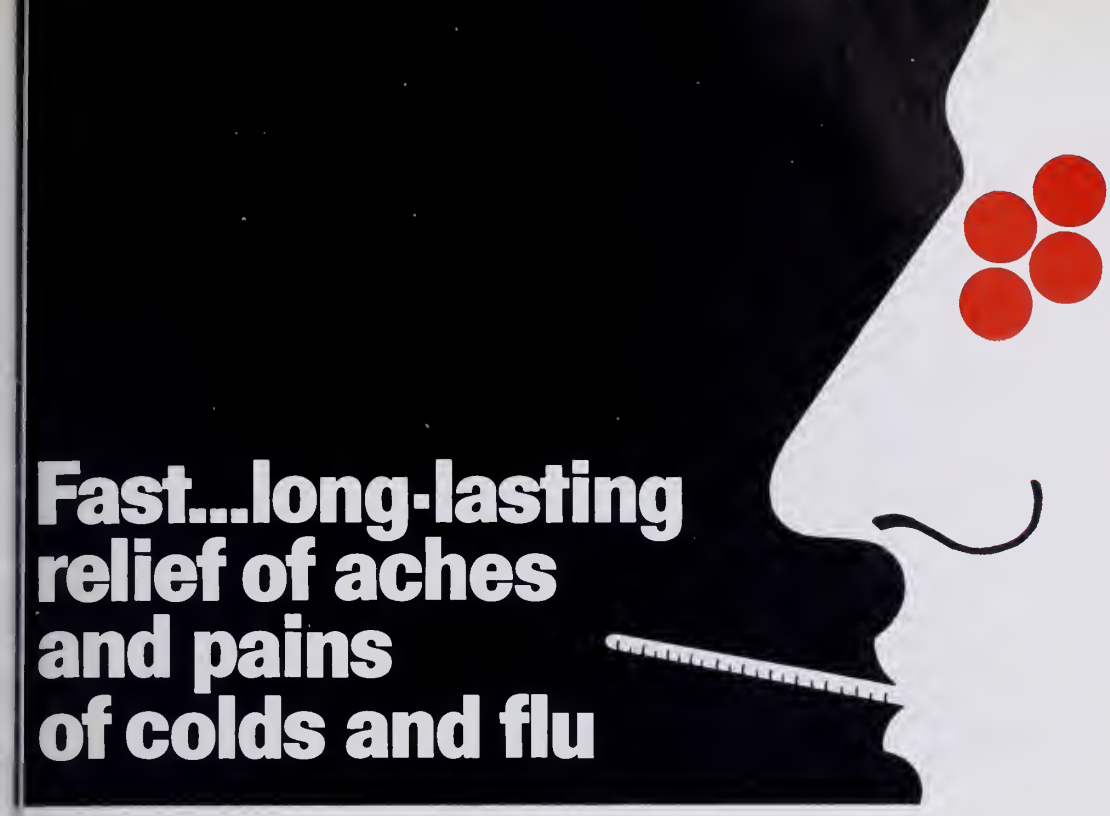
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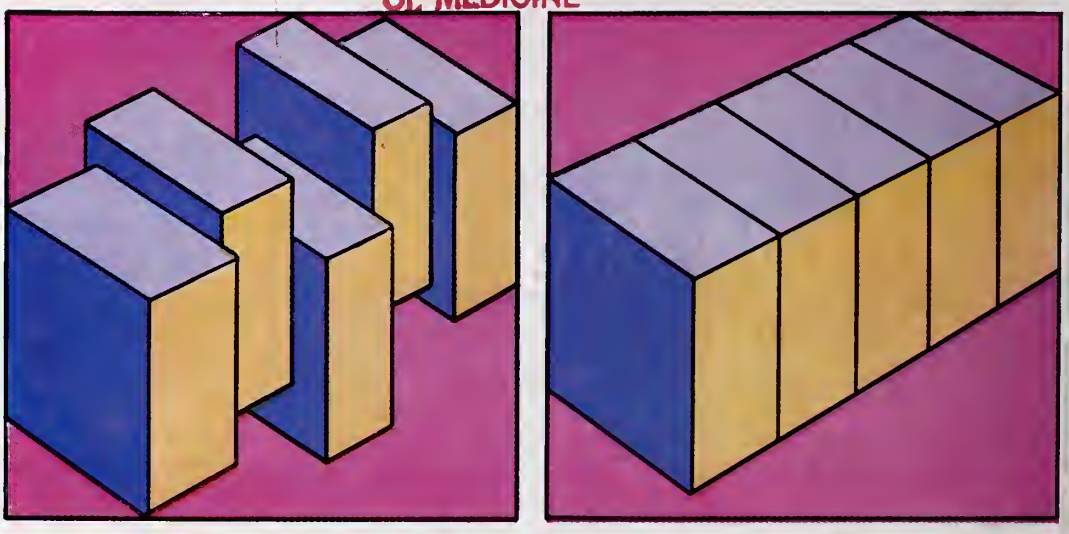
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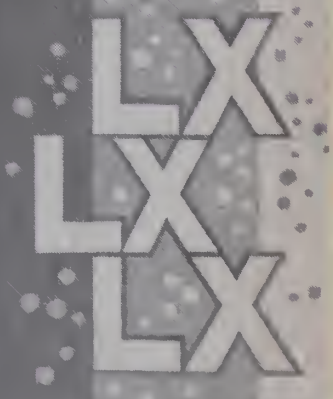
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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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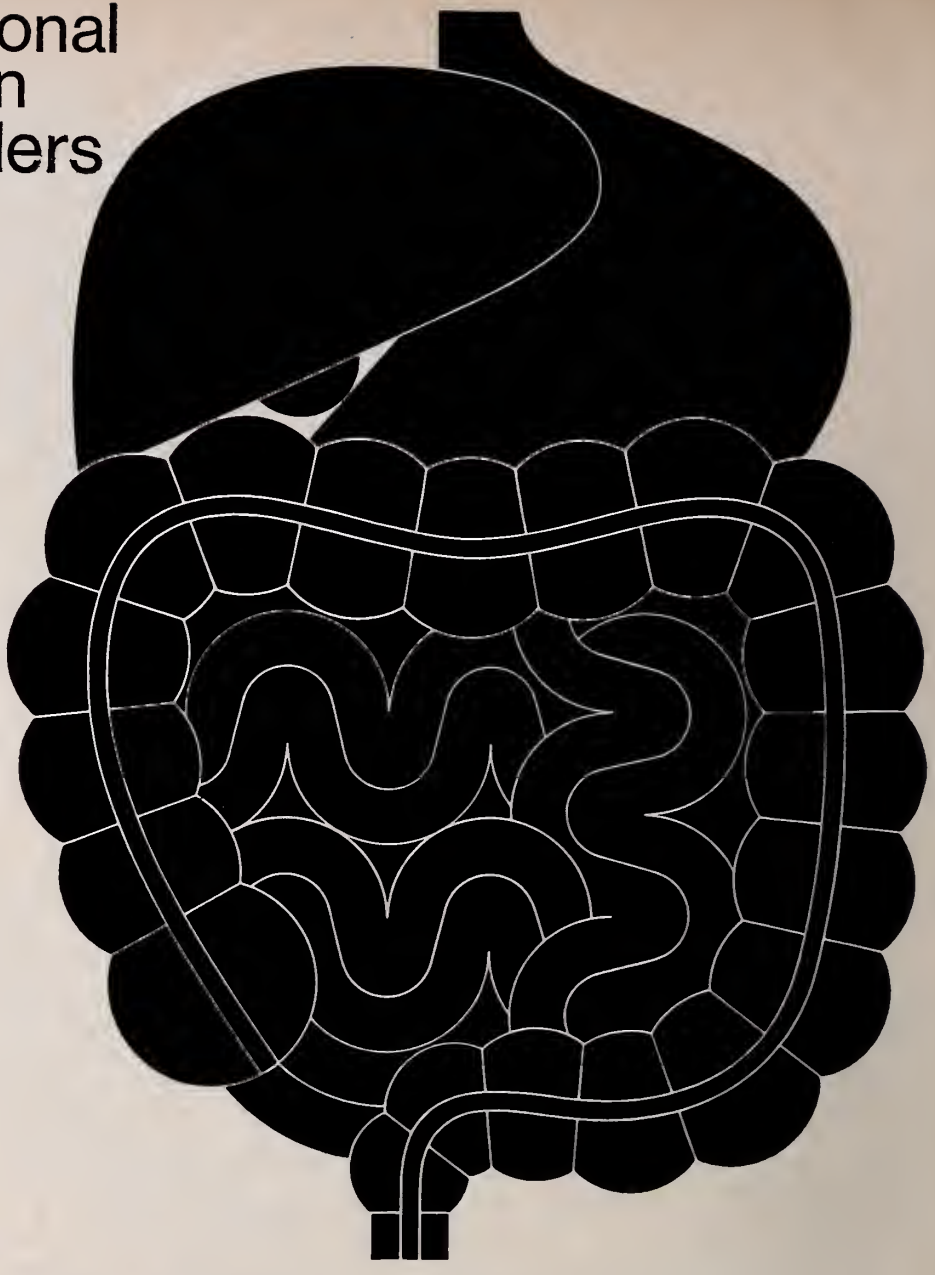
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Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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See Clinical Considerations section on last page...

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Proven clinical effectiveness



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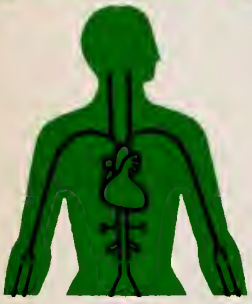
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Septicemia

May be lifesaving[4-6]

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GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

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No other antibiotic performed comparably *in vitro* against gram-negative pathogens.
In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains Number of strains tested Antibiotics*							
	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	99.5% 962	84.7% 992	86.2% 995	76.1% 67	32.7% 1,020	96.3% 640	82.9% 1,028	77.1% 1,026
Aerobacter aerogenes	95.9% 2,739	86.1% 2,818	53.5% 2,985	58.8% 1,514	22.7% 3,066	88.6% 2,603	85.8% 3,071	67.8% 2,981
Klebsiella aerobacter group	98.8% 566	83.9% 547	66.1% 522	60.5% 276	28.0% 553	89.5% 560	86.2% 587	62.8% 433
Klebsiella, all others	92.7% 2,944	83.3% 3,186	77.4% 2,976	67.5% 627	13.5% 2,883	95.0% 2,105	81.6% 3,212	70.6% 3,063
Pseudomonas aeruginosa	91.6% 4,528	29.8% 4,460	6.6% 4,418	6.6% 1,279	6.0% 4,360	91.3% 3,852	26.9% 4,608	26.4% 4,404
Proteus, indole-positive	91.8% 1,031	85.8% 1,062	39.9% 981	54.1% 364	40.2% 1,042	10.3% 758	76.1% 1,096	42.1% 1,051
Proteus mirabilis, indole-negative	94.9% 3,272	90.1% 3,378	83.1% 3,290	77.5% 975	78.0% 3,274	8.8% 2,634	85.9% 3,469	26.8% 3,278
Proteus, unspecified	96.2% 1,335	85.8% 1,371	71.7% 1,434	70.0% 647	64.7% 1,435	11.2% 1,233	76.0% 1,421	22.4% 1,298
Escherichia coli and all other *Escherichias*	96.4% 12,557	91.4% 12,818	87.8% 12,686	88.8% 4,251	74.6% 12,899	95.4% 10,623	94.1% 13,086	70.0% 12,559
Paracolobactrum, all	93.4% 303	88.9% 325	62.0% 305	74.2% 62	43.8% 340	80.9% 215	87.1% 350	72.6% 340
Coliform bacteria	99.0% 593	91.2% 649	81.5% 637	66.7% 21	52.7% 624	95.6% 607	91.6% 678	76.1% 637
Totals	95.1% 30,830	80.5% 31,606	65.3% 31,229	68.1% 10,083	50.3% 31,496	75.8% 25,829	79.7% 32,606	56.5% 31,070
Gram-positive (Included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus,* coagulase-positive	97.4% 1,548	88.8% 1,458	97.7% 2,050	98.7% 636	61.1% 1,559	20.4% 628	94.4% 2,123	83.7% 1,966
Staph—*S. aureus,* unspecified	99.3% 993	92.8% 902	98.1% 1,289	95.3% 213	45.8% 1,153	29.3% 116	96.4% 1,427	82.3% 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).[6]
Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.
Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.
Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.
It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable Garamycin®
brand of gentamicin sulfate injection

See Clinical Considerations section on last page...

Injectable Garamycin®
brand of gentamicin sulfate injection

Schering

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	Resistant/ Moderately Severe	Serious/Life-Threatening
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those wit pre-existing renal damage, treated with GARAMYCIN Injectabl usually for longer periods or with higher doses than recommende

GARAMYCIN Injectable is potentially nephrotoxic, and thi should be kept in mind when it is used in patients with pre-existin renal impairment. Kidney function diminished by infection of th upper urinary tract may, however, improve during effective treat ment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such a streptomycin and kanamycin or of potentially nephrotoxic drug such as polymyxin, colistin, and kanamycin with gentamicin sulfat has not been shown to afford any clinical advantages and, moreove may result in additive toxicity. Monitoring of vestibular, cochlea and renal function will provide guidance for therapy in such case

Precautions: In patients with impaired renal function in whon serious infection develops, serum concentrations of the drug ma rise, with consequently increased risk of ototoxicity. In these pa tients or in those in whom recommended dosage or duration o therapy must be exceeded as a life-saving measure, routine studie of kidney function should be performed when possible. These ma be supplemented by evaluation of the vestibular and auditory func tion and measurement of serum concentration of the drug whe feasible. Serum concentrations of gentamicin should be maintaine below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 1 days or be repeated unless required for serious infection not re sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectabl may occasionally result in overgrowth of nonsensitive organisms. I superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity o nephrotoxicity have not been established. Studies in pregnant ani mals have not revealed teratogenic or ototoxic effects in the fetus GARAMYCIN Injectable should not be used in pregnant patients o in women of childbearing age unless its use is deemed advisabl by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cen (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 1 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin in gram-negative urinary and pulmonary infections, Arch. Int. Med. *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., and Smith, J. K.: Gentamicin in the treatment of pulmonary infections, J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a new aminoglycoside antibiotic: Clinical and laboratory studies in urinary tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clinical experience with gentamicin, data from 12 German clinics, in Gentamicin: First International Symposium, Paris, January 1967 Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Laboratory and clinical investigation of gentamicin, *ibid.*, pp. 62-74. (6) Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, H.: Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommended in Package Insert.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

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All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

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When ephedrine is too exciting or is contraindicated

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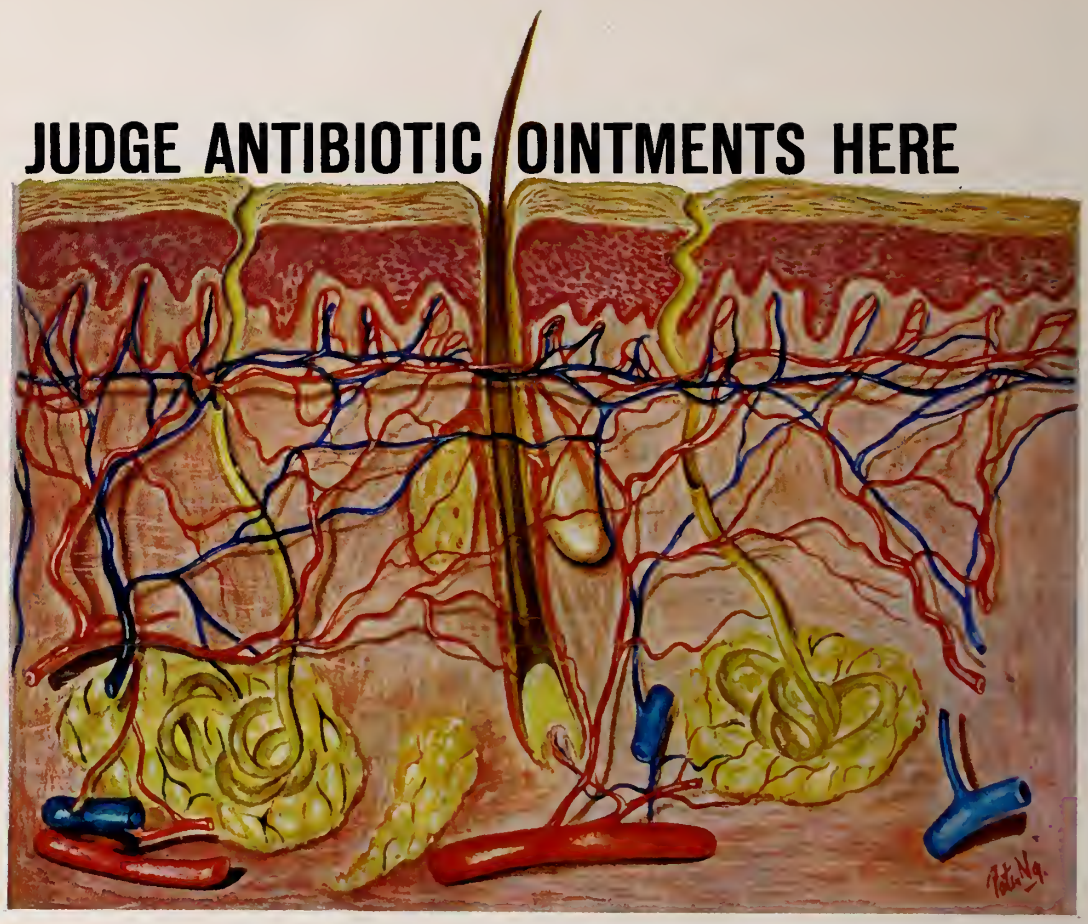
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No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

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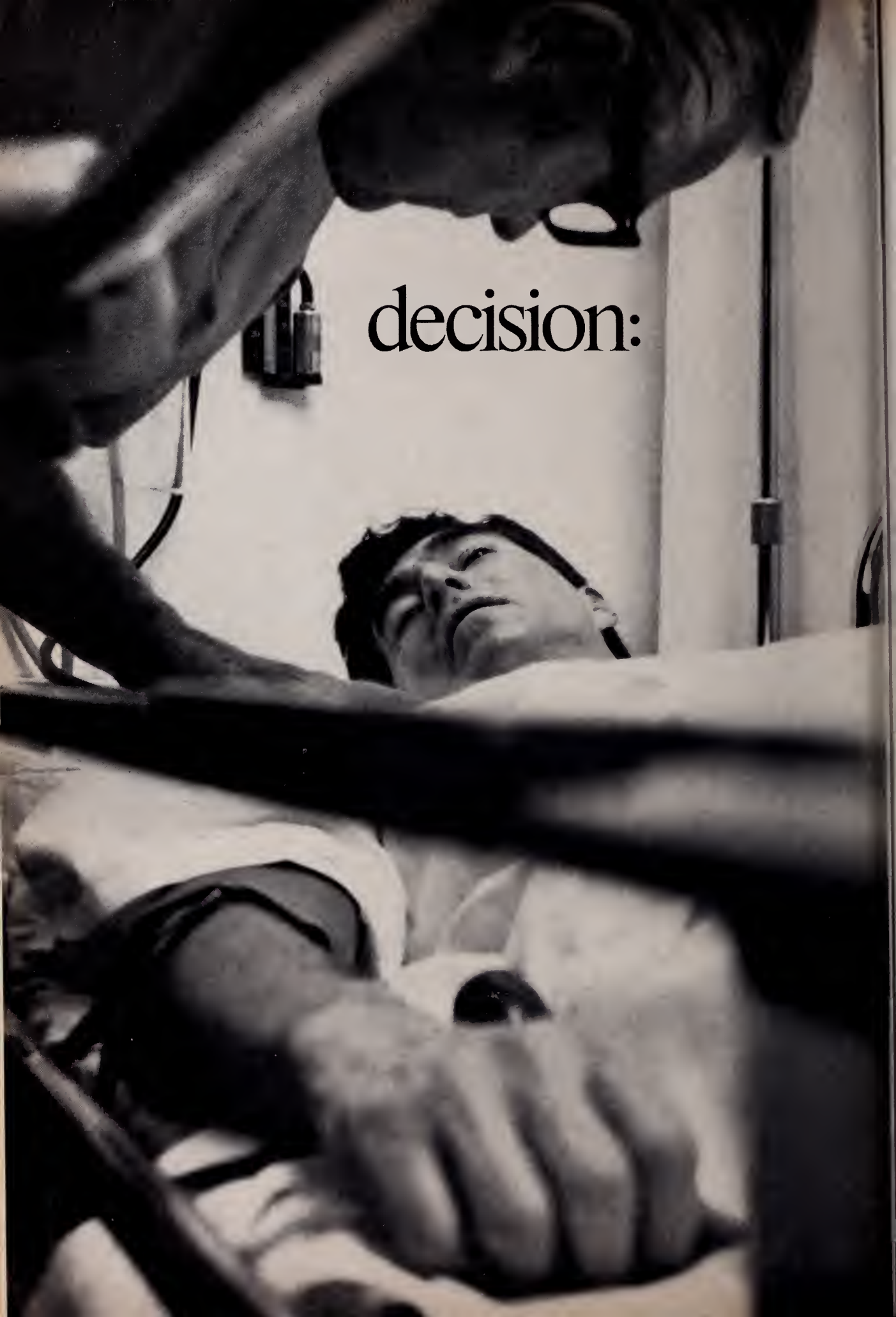
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Loridine® I.M.
Cephaloridine

1.5 to 3 Gm. daily successfully treats many moderately severe infections*

- bactericidal action in vitro against susceptible organisms causing:
  pneumonias following surgery
  abscesses
  wound infections
  infections following compound fractures
  urinary tract infections
- broad-spectrum activity
- relatively painless I.M. injection
- logical I.M. follow-up to I.V. cephalosporin therapy

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

Lilly

000904

Loridine®
CEPHALORIDINE

Please turn page for prescribing information.

Loridine®
CEPHALORIDINE



Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

Additional information available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

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'What she really needs, Doctor, is a shot of penicillin.'

Maybe. Maybe not. In any case she needs something to control her sneezing, watery eyes and runny nose. And for most children over six, Novahistine® LP can be depended on to provide fast relief from summer colds and allergy. These continuous-release tablets have a vasoconstrictor-antihistamine formulation that begins working in minutes, then continues to provide relief for hours. A single Novahistine LP tablet, morning and evening, can keep most young patients free of symptoms all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

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Clinical Extension of a pure Smooth Muscle Relaxant

TROCINATE®

Brand THIPHENAMIL HCl

400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS . . . *the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically.* (*J. Urol. 73:487-93*)

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 800 mg. dosage usually entails a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action assures a conclusiveness of the first suppression of return of symptoms . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually arrest spasm and leave a few tablets for a reserve.*

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals

The girth control pill



Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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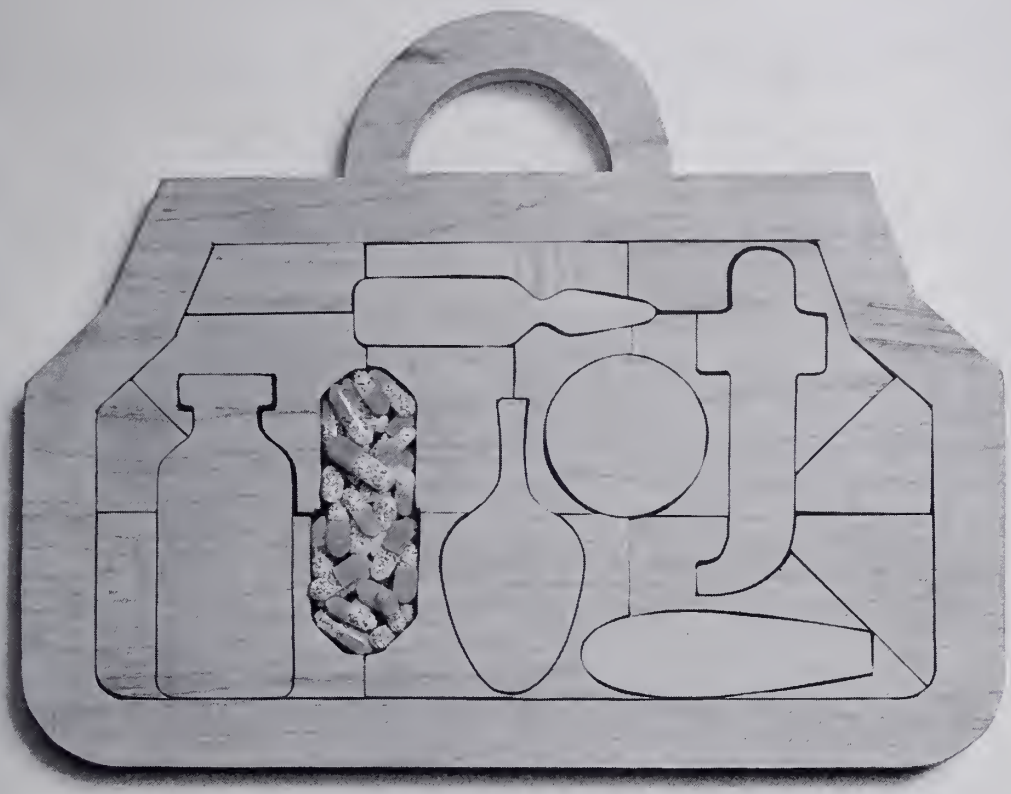
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EDITORIALS

Our New President



Emanuel M. Satulsky, M.D. took office last month as the 178th President of The Medical Society of New Jersey.

He has practiced in Elizabeth since finishing internship there in 1935. He was in the class of 1934 at the Medical School of the University of Maryland. Following the completion of internship, he spent several years in general practice before beginning specialty training in dermatology and syphilology at New York's Postgraduate Medical School and Hospital, and the study of tropical medicine at the Army Medical School in Washington. Dr. Satulsky is board certified in dermatology and syphilology, a senior attending dermatologist at the Elizabeth General and Alexian Brothers Hospitals, and a consultant in dermatology at the Rahway Hospital. He fulfills the obligation of all of us, to be active in civic affairs, and has served as a Board of Health Commissioner in his home city. He is a Fellow of the American Academy of Dermatology, a past-president of the New Jersey Dermatological Society, and an alternate delegate to the AMA.

During World War II, he had five busy years on active military duty. For his work in Central America, he was decorated by the Republic of Panama with the prized Order of Vascos Nunez de Balboa. He was married to the late Dorothy Marie Satulsky. His son, Lewis, a graduate of Lafayette, is a candidate in a master's degree program at the University of Pennsylvania. His daughter, Linda, is a senior student at that college. Dr. Satulsky has served the Union County Medical Society in most of its offices and had an active year as the President of that component. He has thus combined the duties of a good clinician (which is surely every doctor's number one duty), a dedicated worker within the ranks of organized medicine, and an effective contributor to civic activities in his home community.

The Fish In Man

One of the conspicuous differences between modern medical curricula and medical school studies prior to 1930 has been the emphasis on electrolytes, body fluids, and ion exchanges. The importance of fluid and electrolyte balance emphasizes the fact that we all came out of the sea, and that there is still much of the fish in man. The menstrual cycle itself is reminiscent of the influence of the moon on tides. The salinity of our body fluids mimics the salinity of the ocean. And in a way "man is a collection of semi-permeable sacs." The whole body, indeed, may be visualized just that way. And much of human physiology may be thought of as movement of fluid and electrolytes across semi-permeable membranes.

Nature has provided an awesomely complex but efficient fluid and electrolyte balance. It does not tolerate persistent abuse, however. We are not, like the camel, able to reprocess

waste urea into new protein, or lose vast quantities of total body fluid without going into shock, nor are we constantly clothed in a camel's hair coat which valiantly assists in the maintenance of body temperature, thus reducing the role of evaporation.

In a sense, all life depends on differences in ion concentrations on opposite sides of our many semi-permeable membranes. Any such difference sets up an electrical potential, without which muscles and nerves would lose all excitability. Sodium and potassium ions move in and out and across and symbolize the movement that is of the stuff of life itself. Electrolytic rest, perfect ionic balance, and impenetrable inter-sac membranes would mean only the frozen stability of death.

All this has clinical meaning, too. Hypokalemia, for instance, is a common and serious metabolic disorder. Its intelligent management requires more than mechanical following of instructions found in a tabulation in a medical journal. The doctor has to know something of the complex physiology of electrolyte balance, too. Indeed, we must learn to think less in terms of classical disease entities (apoplexy, cholelithiasis, dysentery) and more in terms of hydration, ion exchange, and electrolyte balance mechanisms.

It has been said that increasing knowledge of biochemical factors in disease has reduced the need for concern about emotional components. The two, however, are not incompatible. Emotions have a swift and measurable effect on electrolyte metabolism. The emotions of anger and apprehension increase sodium excretion. Depression and quiet tension decrease it. A man in delicate cardiac balance may be hurt or helped by the physician's attitude. If a patient has decreased cardiac reserve, an episode of decompensation may be precipitated by a discouraging attitude on the part of his medical attendant.

There are no dichotomies of "either-or" in medicine. Man's marine heritage is still apparent in his body physiology; but the emotional superstructure that has been added after eons of evolution is there, too.

Margaret Bertland Takes The Auxiliary Helm



Warren County and Hunterdon County may be small, but some good things, ideas, and people come from there. One was Margaret Bertland who was born in Flemington, but who moved to Washington (NJ) when her husband, Dr. Alexander Bertland, opened his office there. She has made herself one of the most useful citizens of Warren County—secretary of the town planning board, president of the borough's Woman's Club, trustee of the library, and a ceaseless worker for the Red Cross Bloodmobile program. With her husbend, she shares an interest in architecture and the adjustment of foreign students to the United States culture. In the Auxiliary she has been a dynamo, having served the Warren County Auxiliary at almost every level. Her two sons are attending college.

So, we of The Medical Society of New Jersey give a welcome to the new Auxiliary President, Mrs. Alexander Bertland.

ORIGINAL ARTICLES

Our new President here reviews some of our problems in the stormy decade ahead.

Medical Care And The New Decade

Emanuel M. Satulsky, M.D./Elizabeth

As I prepare to assume office as the 178th President of this great and honorable Society, I am not unmindful of the responsibilities which that office presents. You, my colleagues, have conferred this singular honor upon me. I humbly and proudly accept the weighty and important assignment, and I pledge you my constant and sincere efforts to prove myself worthy of your trust, as have the illustrious men who are my predecessors in office.

The Medical Society of New Jersey is vigorously alive in its 204th year. It grows, it matures, and it leaves its mark on all those who are drawn to it It has some faults which conflict with its ideal, but its members continually battle to improve and strengthen it because they understand its unique character and position. The Medical Society of New Jersey and the medical profession are both as fragile and as strong as those who compose them. Physicians originally organized into associations for the improvement of medical education, research, and practice, to enhance the public health, and to protect the public. The aim was to do those things because they needed to be done, and not to add to the prestige of the individual members.

I agree with those who do not look on political participation in the problems of health care in this nation as a temporary do-good attitude or philosophy and who regard it as the inevitable price of our national commitment to a full-employment economy and governmental involvement in the every-day life of our citizens. The history of our relationship with governmental agencies is one of missed opportunities—and not all on our side. The longer we engage in periodic and frantic rear-ground actions to postpone that which cannot be postponed rather than assuming constructive leadership to provide adequate medical care to all our people, the more remote will become the time when we shall really exercise the influence in the community to which our abilities, our experience, our humanity, and our dedication entitle us.

By preparing for leadership and acting in intelligent cooperation with other social forces, with adequate peer review mechanisms to establish professional and ethical standards which must be met, and with proper disciplining and control of those who fall short of those standards, we shall contribute constructively to our changing and demanding world.

The emphasis on the present and the future is intentional. While we are proud of our history and of the people who helped build this Society, our principal concerns are with the people, the problems, and the opportunities of today and tomorrow. The decade ahead is not likely to be tranquil or static or secure or comfortable. It will be character-

*Delivered to the House of Delegates, 204th Annual Meeting, MSNJ, May 17, 1970, Atlantic City.

ized by rapid and drastic change that will force us to make major adjustments in the way in which we live and work and think. It is difficult to believe that changes in our Society and in the way we live more fundamental that those of the past decade can possibly occur in the next fifty years. Yet the role of government and the pace of science and technology are broadening and accelerating, and I have no doubt that even more dramatic changes lie ahead, some of them in the immediate future. As Lincoln said, "The dogmas of the quiet past are inadequate to the stormy present . . .As our case is new, so must we think anew and act anew . . .We must disenthrall ourselves."

It has been said that in the past decades there has been a great increase in expectations on the part of the public. The people expect better housing, education, environment, transportation, and health services. It has also been said that we are living in an age of unreasonable expectations, in an age of rising rash expectations, in which advances in so many fields have been made and publicized that expectations are becoming demands that do not take into consideration the complexities, the interrelationships, the scope, and the ultimate cost of the social programs that have evolved. More and more people are looking to government to supply their needs and their demands and they are not given to distinguishing one from the other. In consequence the emerging great problem of our times is not how to create change, or how to adapt to it, but rather how to direct and control it so that it does not overwhelm us and destroy the principles and fundamentals that alone make success possible. We must, in the face of the tide of change that is sweeping our way keep in mind the elementary points of our position: 1) That the availability of adequate health care is a basic right of all our citizens; 2) That free choice on the part of the citizen of his physician and of the institution which is to supply health care services to him is also a basic right; and 3) That it is the fundamental responsibility of the medical profession, using all means at its disposal, to strive to deliver adequate medical care to every person needing it.

There is a statement of an anonymous author which I think bears repeating: "The history of all democratic societies has been from bondage to spiritual faith, from spiritual faith to courage, from courage to freedom, from freedom to abundance, from abundance to selfishness, from selfishness to dependence, and from dependence to bondage."

Organized medicine has always been cautious toward embracing change. Medicare and Medicaid have recently been established, and now there is an increasing trend toward governmentally subsidized and directed universal medical care. The limited programs already in operation are being continually modified by governmental regulations and directives. It is inequitable and wrong for government to promise to pay the costs of medical care and then to ask providers of that medical care to subsidize the costs thereof.

There is always the possibility that the federal government may move to take over the processes of examinations and licensure, overriding the present system of medical licensure by the individual states. With each new enlargement of governmental influence over medical practice, the freedom of medical practice and of medical practitioners will be progressively curtailed. Regimentation may force doctors to take prescribed post-graduate work at regular intervals, whether indicated by the needs of their patients or not, under the threat of withdrawal or limitation of their licenses in hospital staff privileges, if they fail to comply.

Medicine has always been dedicated to the delivery of quality care to each patient and to the utilization of the best and most dependable means for the attainment of that end. Government initially freely promised to abide by that dedication, but as experience mounted, it indulged a modification of its thinking. In the interest of economy government is now concerned about limiting the physician's freedom to choose the regimen of

treatment and of medication for his patient. It has leaned, for example, toward establishment of a national formulary to delimit the physician's choice in prescribing for his patient's medical needs.

Compulsory re-distribution of physicians is a distinct possibility, as is the decision as to whether medical practitioners should remain free to decide whether to serve in solo or in group practices, on a fee-for-service or on a salaried basis under prepayment programs. All these questions confront us as the day draws nearer when we shall have to decide whether we are to serve as free men or as vassals of a system, as men and women who have chosen and direct their own careers or as men and women who have been sentenced to them.

We must with increasing dedication and devotedness show ourselves, individually and collectively, genuinely committed, as free men of dignity and dependability, to the true health and welfare of the people whom we serve. We must intensify our participation in constructive community activities by assuming greater civic responsibilities, especially in studying and developing methods of elevating the quality and improving the delivery of medical care.

Because we live in a troubled world beset with violence, turmoil, and myriad social problems, we must develop a closer association with those involved in the social sciences. Based on intuitive judgments from experts, computers have come up with several predictions: population will have more than doubled by the year 2019, general immunization against bacterial and viral disease will be available, elimination of hereditary defects by using molecular engineering will be possible, effective fertility control will be practiced, automation which will reshape industrialization will replace at least one quarter of the present work force, psychiatric problems and other problems will arise and continue as a result of physio-psychologic stress produced by overcrowding, poverty, pollution, crime, and disease. Although automation may provide greater efficiency in the delivery of services, it may also eliminate the factor for recovery that depends on the human relationship between doctor and patient. There are many subjective factors in medical care which science has not yet been able to measure or standardize. Economic factors and social progress invariably introduce new hazards to health, and the physician must be aware of the increasing role he plays in society.

I am convinced that those who contemplate specialization should spend at least one year in private, general practice before being allowed to enter a residency program. This would produce more G. P.'s because many young physicians, once forced to work and think as family physicians, would make general practice their career. Those who then go on to a specialty training could not help being better specialists with a broader understanding of the problems of their fellow practitioners and with some insight into the art of medicine as it must be practiced at the grass-roots level.

We must work toward the day when there will be a place in the schools of medicine, nursing, and other allied health fields for all qualified students who desire to enter. The medical man-power crisis that experts have been predicting for years is upon us now. A Public Health survey puts the 1970 shortage at 52,200 doctors. I call upon all medical schools to take action drastic enough to match the critical condition that exists. First year enrollment for 1969-1970 in all schools is slightly over 10,000—which indicates an insufficient rate of growth; there are approximately 9,000 rejections yearly, and in this number there must be many who are qualified for admission by reasonable standards. By fuller use of existing facilities and by re-designing professional education, the medical schools of this country can stop the large number of American citizens who must seek their educations in foreign medical schools. Medical schools must re-examine and improve their curricula. Some are already de-

veloping a system whereby there may be different pathways through the curriculum, depending on the career goal of the student. We are deeply committed to medical education and we should be proud of the accomplishments of our professional schools in teaching basic biomedical sciences and clinical skills. I agree with those who say it would be disastrous if we developed programs that turned out social do-gooders who lack the necessary scientific backgrounds, intellectual discipline, or technologic capability required of the modern day physician.

We have made great strides in American medicine and we have done our job well. Unfortunately, on the heels of enormous public spending, the public and government at all levels are taking an increasingly critical interest in medicine. We must be ready to meet the complex health-care problems of this new decade and devise efficient means to develop and operate health-care delivery systems. I feel the situation is urgent and the challenge exciting. We have the opportunity, the talent, and the capability to prepare for a better and different form of medicine, and I believe it will be better and different if we are the architects of the change.

I close with an exhortation written by Sir Thomas Browne: "Live by the old ethics and the classical rules of honesty. Put no new names or notions upon authentic virtues or vices. Think not that morality is ambulatory; that vices in one age are not vices in another; or that virtues which are under the everlasting seal of right reason, may be stumped by opinion. And therefore, though vicious times invent the opinion of things and set up new ethics against virtue, yet hold onto the old morality; and rather than follow the multitude to do evil, stand like Pompey's Pillar conspicuous by thyself and single in integrity."

737 North Broad Street

More GPs By Act Of Congress

Bills designed to increase the number of physicians and allied health personnel in family medicine have been introduced in the House and Senate. Sponsors of the legislation say that prospects are good for Congressional approval this year. This legislation would authorize $50 million for the current fiscal year, then $75 million for fiscal 1972, and $100 million for each of the next fiscal years for grants to medical schools and hospitals. The grants would be to help medical schools and hospitals to establish departments and programs in family practice of medicine and to encourage the training of allied health personnel in that field of medicine.

Senator Ralph W. Yarborough sponsored the legislation (S. 3418) in the Senate. Thirty-one other senators, both Democrats and Republicans, were cosigners of the bill. Senator Yarborough is chairman of both the Senate Labor and Public Welfare Committee and the Subcommittee on Health which will handle the legislation. An aide said the Senator would schedule hearings and that he was confident the Senate would approve the legislation this year.

Congressman Fred B. Rooney introduced the bill (H.R. 15793) in the House this year. Representative Rooney is a member of the House Interstate and Foreign Commerce Committee which will handle the legislation on that side of the capitol. Several other House members also introduced it separately.

Aides to both Yarborough and Rooney said they had worked with representatives of the American Academy of General Practice in drafting the legislation.

When the ureter opens into the sigmoid, you would expect trouble during the delivery. Here is one of the few cases reported—and mother and baby did well.

Pregnancy In A Patient With Uretero-Sigmoid Anastomosis*

Cheng Hung, M.D./Newark
Harold M. Jesurun, M.D./El Paso, Texas

Pregnancy in a patient with uretero-sigmoid anastomosis is extremely rare.[1] Only 25 cases have been reported in all the English literature.[2] The major complications to be expected are upper urinary tract infection,[3] hyperchloremic acidosis,[4] and possible damage to the perineum and anal sphincter following vaginal delivery. In most cases the indications for the ureteral transplantation were: extrophy of the bladder, inflammatory disease, trauma, vesico-vaginal fistulas and congenital anomalies. The following case is reported here because of its rarity, the considerable length of time during which the anastomosis was in effect and the unusually uncomplicated course during pregnancy and the puerperium with no apparent damage suffered by the kidneys and ureters, as evidenced by a repeat intravenous pyelography three months after delivery.

A 28-year old female, gravida I, para O, was born with a congenital extrophy of the bladder. At the age of four, she had a two-stage uretero-sigmoid anastomosis, a total cystectomy and plastic repairs of the abdominal wall and external genitalia at the Medical College of Virginia. At that time she presented with a wide separation of the symphysis and incomplete labia majora. No anterior vaginal wall was present. Pyelogram revealed a moderate hydronephrosis of the left kidney. She had an uneventful post-operative course and remained symptom free through the years.

Menarche was at the age of fifteen and menstruation has been normal in rhythm and amount. The patient was married at the age of twenty and did well until 1965 when, at the age of 25, she developed acute bilateral pyelonephritis. The only way "urine" cultures were obtained was through the rectum and of course showed a mixed flora of E. Coli and proteus vulgaris. Pyelogram then showed a slight to moderate hydronephrosis of the left kidney and a normal right kidney. Electrolytes and chemistries were normal. The patient was hospitalized for one week and treated with Ampicillin^{R} with success.

Ten months after this episode, she developed recurrent pyelonephritis for which she was hospitalized for two weeks and received Kanamycin^{R} and Ampicillin.^{R} Pyelogram showed very little change from previous studies. However, a definite calcification overlying the inferior pole of the left kidney, interpreted as a renal stone, was described.

On March 4, the patient came to our prenatal clinic; expected confinement was July 12, 1968. All laboratory studies, electrolytes, and chemistries were normal. A "urine" culture grew hemolytic streptococci (30,000 colonies) and enterococci (80,000 colonies). She was completely asymptomatic. Physical examination was normal except for a wide separation of the symphysis, absence of an umbilicus, a large scar on the lower abdomen

*This case is from the obstetrical and gynecologic service at St. Michael Hospital in Newark, when both Dr. Hung and Dr. Jesurun were on the staff there. Dr. Hung read this paper at the October 30, 1968 meeting of the New Jersey Obstetrical and Gynecologic Society.

and a shortened anterior vaginal wall, she had no stenosis of the vaginal tract and she did have a tight perineal body. The patient walked with a peculiar gait shifting from side to side as she walked. She stated that she and her husband tried for a pregnancy since their marriage but had not been successful until now.

The patient was seen at the clinic very frequently, sometimes as often as three times a week and other times at lesser intervals. She followed instructions carefully. Blood pressure never rose above 130/70; frequent chemistries remained normal (below 10 mg%). She did not develop edema nor signs or symptoms of pyelonephritis nor superimposed toxemia. Total weight gain was 14 pounds. During her 37th week she was placed on oral diuretics for a short period of two weeks because of a slight excessive weight gain during that period. It was felt that this represented fluid retention in spite of no demonstrable edema. She was on Ferrosequels[R] and Filibon[R] during her pregnancy but never received antibiotics, bacteriostatics or urinary antiseptics. She was continuously instructed to force fluids and frequently to empty her bowels of the collected urine even if she did not feel the urge to defecate. Twice during pregnancy the fetus was found in transverse lie and was converted to vertex.

Two weeks after the estimated date of confinement she was admitted because of spontaneous rupture of membranes without labor. The fetus was in vertex presentation and felt fixed in the pelvis. Pelvimetry was taken and we found no bony disproportion; there was a wide separation of the symphysis. Induction was started with 5 units of oxytocin in 1000 cc glucose in water. After seven hours of active labor and twenty minutes of full dilation she was delivered of an 82 ounce baby boy, with an Apgar of ten, by low forceps saddle block anesthesia over a wide right mediolateral episiotomy. No gross anomaly was found. She was discharged on the fifth postpartum day after an uneventful course.

Six weeks after delivery, blood pressure was normal. There were then no signs or symptoms of urinary infection. Healing was complete; there was excellent support. The uterus had involuted normally and was anterior, right under the cystectomy abdominal scar. Rectal examination revealed excellent sphincter tone. Pyelogram three months postpartum disclosed promptly functioning kidneys bilaterally with slight hydronephrotic and hydro-ureteral changes on the left compared to the right. The left renal stone originally described in 1966 remained unchanged in size and position.

Without doubt, these patients must have a chronic smouldering infection of the urinary system. Yet pregnancy does not necessarily seem to increase the renal damage. Pregnancy is not contraindicated unless there is a serious diminution in kidney functions, or marked infection. Labor and vaginal delivery are the preferred route since this does not damage the anastomotic site. It is important that during labor and after delivery ample fluids are given and that bowels are emptied frequently of their collected urine. With conduction anesthesia where labor and delivery are under good control, and with a cooperative patient, the rectum and sphincter can be protected to withstand vaginal delivery unharmed. Cesarean section, although it may appear as the "easiest way out," is really not performed unless it be for other obstetric indications.

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206 High Street (Dr. Hung)
4815 Alameda Avenue (Dr. Jesurun)

Once considered non-pathogenic, Serratia Marcescens has been identified as causing a serious, sometimes fatal infection in hospitalized patients.

Serratia Marcescens Infections*

**Steven Alexander, M.D.;
Bernard D. Pinck, M.D.;
and Gerda Petzall/Passaic**

The emergence of a formerly innocuous organism as a virulent pathogen is a matter of significant clinical interest. Recent reports have described serious infections produced by *Serratia Marcescens*†, which is a gram-negative bacillus, one of the species of enterobacteriaceae within the tribe klebsiella. Some strains produce a red pigment, prodigiosin. In the past *Serratia Marcescens* has been generally considered to have a few or no pathogenic qualities. However, this organism has now been identified as an etiologic agent that can cause meningitis, urinary tract infections, pneumonia, empyema, wound infections, peritonitis, sinusitis, otitis media, and endocarditis.[1] Furthermore, septicemia due to *Serratial* infections are increasingly being encountered.

During the past six months, *Serratia Marcescens* has been isolated from the urine in six patients at the Passaic (New Jersey) Beth Israel Hospital. We present this report to point up the salient features regarding its isolation, complications, and clinical management.

Bacteriologic Methods

Serratia Marcescens is identified in the laboratory[2] on the basis of colonial morphology on blood agar and eosin-methylene blue agar, and appropriate biochemical tests. It is a motile organism and it ferments glucose with little or no gas, ferments sucrose and mannitol without gas, and does not ferment lactose in 48 hours. Other biochemical features are:

Simmons Citrate	—Positive
Hydrogen Sulfide	—Negative
Indole	—Negative
Gelatin	—Rapid liquefaction
Arabinose	—Negative
Sorbitol	—Positive
Urease production	—Weakly positive after 48 hours

On Triple Sugar Iron Agar (T.S.I.) *Serratia* produced an acid butt with very little gas, and a very small alkaline tip. However, a large portion of the slant became alkaline after 48 hours.

Identification of these colonies is confirmed by the inoculation into raffinose and D Nase media. After overnight growth the media is flooded with normal hydrochloric acid. Since *Serratia* produce desoxyribonucleic acid, there will be a clear zone surrounding its growth. The organism does not ferment raffinose.

All of the strains isolated were non-pigmented except for one which produced a pale orange color on plain agar. However, this disappeared before subculture studies were begun. Routine sensitivity studies were carried out on all of the cultures. Chloramphenicol and gentamicin were the antibiotics to which the organism displayed the most sensitivity.

Clinical Experience

Six patients with urologic disease or complications were found to be infected with *Serratia*. In all, more than one positive urine culture was obtained. In one instance, the organism was also isolated from a draining flank wound. Essential clinical data are tabulated below:

Case 1.—Male 60
Diagnosis: Carcinoma of the Prostate Gland
Operation: Transurethral prostatectomy and an indwelling Foley catheter. This patient was treated with cortico-steroids.

* This work is from the Department of Urology, Beth Israel Hospital, Passaic, New Jersey

† Known to our older readers as *bacillus prodigiosus*

Case 2.—Male 67
Diagnosis: Brain Tumor (Glioblastoma). He needed an indwelling Foley catheter and was treated with cortico-steroids.

Case 3.—Female 28
Diagnosis: Left hydronephrosis and hydroureter
Operation: Left nephroureterectomy. A cystoscopy was done and the *Serratia* was also isolated from left flank wound.

Case 4.—Male 50
Diagnosis: Benign prostatic hyperplasia
Operation: Transurethral prostatectomy. He needed an indwelling Foley catheter.

Case 5.—Female 47
Diagnosis: Left ureteral calculus
Operation: Left ureterolithotomy. A cystoscopy was also done.

Case 6.—Male 74
Diagnosis: Carcinoma of the prostate. An indwelling Foley catheter was used.

All of the patients either had an indwelling urethral catheter or had experienced cystoscopic examination. Three had cancer, and two received treatment with cortico-steroids. Sensitivity studies demonstrated that chloramphenicol was the drug of choice. Gentamicin® was the next appropriate antibiotic followed by Kanamycin®. *Serratia Marcescens* was generally resistant to tetracycline and Ampicillin®. There were no episodes of generalized septicemia. All of the infections responded to appropriate antimicrobial therapy.

Several constant features of *Serratia Marcescens* infections have been emphasized in the last nine years. The first is that it is a nosocomial infection. A recent report by Allen and Conger[3] showed that no patient with a *Serratial* urinary infection had a positive culture upon admission to the hospital. Moreover, there have been no reported positive urine cultures isolated from any large out-patient clinic. No patient in the urology out-patient clinic of the Passaic Beth Israel Hospital suffered a *Serratial* infection, nor have there been any positive cultures in private practices reported by any local physician. In our series, all the patients who had *Serratial* infections were suffering from a chronic and frequently debilitating underlying disorder.[4] Malignancies and diabetes mellitus are regarded as the most common primary diseases encountered.

Instrumentation, catheterization, or some type of urologic surgery was carried out in those patients who developed a positive urine culture for *Serratia Marcescens*.[5] Invariably, an indwelling urethral catheter was present.

In the reported cases of bacteremia, multiple antibiotics had been utilized prior to the onset of the disseminated infection. The incidence of resistant organisms was high, and clinical improvement occurred only when the indicated antimicrobial agent was used.

Cortico-steroid therapy has been a constant pre-disposing factor in *Serratial* infections. In Dodson's series[1] it seemed to affect the outcome unfavorably. Generally, a combination of chloramphenicol and Kanamycin® is considered the best antimicrobial therapy for this infection. Kass[4] recently observed that Gentamicin® was the single most effective drug against *Serratia Marcescens*.

The mortality rate in cases of *Serratial Marcescens* septicemia approaches 40 per cent.[6] It is a particularly serious infection in debilitated surgical patients with pre-disposing or pre-existing diseases. The sources of infections related to complications of continuous intravenous therapy, tracheostomy, or respiratory assistance with mechanical ventilator, and urinary tract catheterization or instrumentation.

Patient survival seems to be well correlated with the prompt utilization of appropriate antibiotics, and strict abstinence from cortico-steroids. Clinical experience suggests that this may be one type of Gram negative septicemia in which cortico-steroids are contraindicated. Other suggestions include the application of closed drainage systems for all urinary catheters, and the proper separation of beds, particularly on a large ward service.

Summary

A rapid and disturbing increase in the number of cases of *Serratia Marcescens* infections has occurred in recent years. This Gram negative bacillus was previously regarded as non-pathogenic for man. However, reports now

indicate that this organism is responsible for serious infections in hospital patients. There is a very significant mortality in *Serratial* septicemia.

The salient bacteriologic and clinical features of *Serratia Marcescens* are here presented. It is imperative that the proper laboratory procedures for the identification of this organism be carefully performed along with antibiotic sensitivity studies. This is a nosocomial infection which has entered the community hospital.

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124 Gregory Avenue

Time To Fire The Coach?

The AMA *News* has just reprinted this brief item from the *Bulletin* of our own Bergen County Medical Society: Congress is now finding that Medicare and Medicaid are expensive. When the laws were passed, their advisers said the costs would be moderate and the results wonderful. Now they have found that the results are only fair and that costs are very high and getting higher. We warned them that this would happen but now it's all our fault.

The congressmen are upset over reports that 10,000 physicians have received $25,000 or more from Medicaid. Though they say that most of this is legitimate, they decry such large collections and threaten investigations and IRS action. Also, they ask doctors to accept lower fees, based on the 75th percentile as of January 1, 1969. In view of the rapid increase in living costs and office expenses, we fail to see how physicians can continue to give their best care to so many reduced fees patients. The original "usual and customary" concept is now being replaced by HEW by a fee schedule based on the lowest Blue Shield figures, which in many states have lagged far behind the current fees for service.

Two recent actions point up the results of this kind of thinking. Druggists in New York City refused to fill Medicaid prescriptions when the state cut them down to 67 per cent of their usual charges. Dentists refused to accept new Medicaid patients because the fees were too low. With ever-increasing overhead, it becomes more difficult to operate under a fixed fee schedule, and doctors are forced to reject the very patients who need them most. There is a limit to the number of patients any doctor can treat at fees which barely cover overhead.

In professional sports, when the team is losing, the solution is to fire the coach. In health care, when things don't run according to plan, it's simple to "knock the Doc." Neither approach solves anything. The time has come for the planners to listen to those who are going to have to make reality out of what is put on paper. We might have a few useful ideas.

For acute mitral insufficiency, replacement of the valve with a prosthesis seems to be better than the traditional medical methods.

Treatment Of Acute Mitral Valve Insufficiency

Adrian M. Sabety, M.D.;
John S. Madaras, Jr., M.D.;
Franklyn P. Gerard, M.D./East Orange

Rupture of the papillary muscle, or the chordae-tendinae of the mitral valve results in acute mitral insufficiency by interference with the anchoring function of these structures. The severity of this abnormal hemodynamic state depends a great deal on the extent of infection, size of the myocardial infarction, degree of rheumatic valvulitis, and the number of the involved chordae-tendinae. In contrast to patients with chronic rheumatic mitral regurgitation, those with acute mitral insufficiency seldom live longer than a year. But today, with the development of open heart surgery and availability of mitral valve prosthesis, satisfactory treatment of these previously hopeless cases has been achieved. The aim of this paper is to present three patients with acute mitral insufficiency (secondary to bacterial endocarditis) who have been treated successfully by excision of the remanent of the mitral valve and replacement with a prosthetic valve.

Case One

This 56-year old man was hospitalized with severe mitral insufficiency and heart failure. A year earlier, he had been hospitalized with signs and symptoms of bacterial endocarditis following an episode of acute gastroenteritis. After more than six weeks of therapy he improved and was discharged. At that time, a full-blown murmur over the mitral area was noticed. Subsequent clinical course was characterized by increasing right ventricular failure and peripheral edema which was fairly well controlled by diuretics and digitalis until the present admission.

At this admission, he had a marked cardiac enlargement, a loud regurgitant systolic murmur at the apex, and an electrocardiogram showing atrial fibrillation, right axis deviation, and abnormal ST-T changes. After a period of rest and medical treatment, cardiac catheterization revealed a marked elevation of pulmonary wedge pressure, indicating comparable elevation of the pressure in the left atrium, and a very sharp and sudden rise to 60 millimeters of mercury of the V-wave in the right lower pulmonary wedge position, indicating a significant regurgitant jet through the area of the mitral valve. There was a severe pulmonary hypertension at rest and a significant elevation of the right ventricular and diastolic pressure indicating myocardial failure.

Since this patient was in a state of irreversible heart failure, it was felt that the anatomic correction of the regurgitant mitral valve was the only way to reverse his otherwise downhill course. The operation took place on January 9, 1964. Under cardiopulmonary by-pass, the mitral valve was exposed through a left thoracotomy incision and the aortic leaflet of the mitral valve was found to be entirely disintegrated and reduced to a small fibrotic tissue contracted to the wall of the ventricule resulting in a massive regurgitation. The remnants of the valve were removed, and the largest size Starr-Edward mitral valve prosthesis was sutured in place. Post-operatively, he was on assisted respiration for about four days, following which he continued to improve and was discharged home on his fourth post-operative week. He has been symptom-free ever since and working, full-time as a salesman. (Figures 1, 2, 3, and 4.)

Case Two

A 50-year old woman was in good health until February, 1968 when she developed cough, fever, and chills. She was treated with versatile antibiotics. The fever did not subside and she was admitted to the hospital. At admission her temperature was 101. She was dyspneic, and chest x-rays showed pleural effusion. She developed a loud systolic murmur over the apex with transmission to the left paravertebral area and along the left sternal border. The murmur was not heard over the carotid vessels. Chest x-rays revealed



Figure 1—Chest x-ray showing pulmonary congestion and bilateral pleural effusion.



Figure 3—Postoperative chest x-ray showing the clearing of the pulmonary congestion.



Figure 2—Left atrium seen to be moderately enlarged.



Figure 4—Postoperative chest x-ray showing a considerable decrease in the size of the heart.

progressive cardiac enlargement. Left and right heart catheterization was performed as well as angiocardiograms. These revealed a massive mitral insufficiency. In view of the progressive deterioration of her cardiac condition, operation for replacement of the mitral valve was decided upon, with cardio-pulmonary bypass and through a right thoracotomy approach. The mitral valve was exposed and the anterior leaflet was found to be freely moving with the flow of blood with no anchoring by the chordaetendinae. The mitral valve was removed in its entirety and a Starr-Edward mitral valve was sutured in place.

Post-operatively, she was placed on a respirator for 48 hours. Post-operative course was entirely uneventful. She was ambulatory on her first post-operative week and discharged on the third post-operative week. On follow-up in January, 1969 she was entirely symptom-free and in full activity with no medication except for the prophylactic anticoagulant (Figures 5, 6, and 7.)

Case Three

This 30-year old man entered the Orange Hospital Center with acute mitral insufficiency, secondary to subacute bacterial endocarditis. While working in the Near East, he developed a fever accompanied by signs of heart failure. In Beirut, the diagnosis of subacute bacterial endocarditis and mitral insufficiency was made. After a period of therapy, he was transferred to the U.S. for further care.



Figure 5—Chest x-ray showing pulmonary congestion and pleural effusion.



Figure 6—Cineangiogram showing the simultaneous flow of the dye from the left ventricle into the inflow and the outflow tract.

Here we found a regurgitant systolic murmur heard best at the apex. A diastolic murmur was heard all along the left sternal border. Electrocardiogram showed auricular fibrillation with early left ventricular preponderance. The chest x-ray revealed a greatly enlarged heart. Cardiac catheterization demonstrated a markedly elevated wedge pressure measuring 40/5 with a tall peaked V-wave of 40 to 42 mm. of mercury. Angiocardiography substantiated the impression of acute mitral insufficiency. At operation, the anterior leaflet of the mitral valve was found to have rolled over completely resulting in a marked degree of incompetence. The leaflets were removed and a Key-Shilley mitral prosthetic valve was inserted. Post-operative course was stormy because of continued fever and signs of septicemia. This eventually subsided after prolonged and massive antibiotic therapy and he was finally discharged home improved.

This patient was readmitted four months post-operatively because of congestive heart failure and jaundice. Recatheterization showed mitral insufficiency. Unfortunately, he died before reoperation could be undertaken. At autopsy, it was found that the prosthetic valve had become separated from the atrial wall along one side; apparently as a result of an area of infection at the site of one of the sutures, resulting in a recurrence of the mitral incompetence which eventually led to his demise.

Mitral insufficiency due to rupture of the papillary muscles was first reported by Corvisart[9] as far back as 1812. This case was apparently secondary to subacute bacterial endocarditis.

The most common cause for rupture of the papillary muscle or the chordae-tendinae of the mitral valve is bacterial endocarditis. This was present in all three of our patients. In one patient, there was a history of old healed rheumatic valvulitis which served as a nidus for infection. Other commonly reported causes are myocardial infarction and trauma, due to a crush injury or blow to the chest wall. Several cases have been reported to have occurred "spontaneously" without any known pre-existing mitral valve disease.



Figure 7—Postoperative film shows increase in the size of the left atrium.

Marchand[1] postulated that annular dilatation of the mitral valve ring, secondary to mitral insufficiency must be present before chordal rupture could occur. Only after the annulus has dilated sufficiently to impair surface apposition of the leaflets do the chordae come under pathologic strain. Chordal rupture results in a sudden aggravation of the already pre-existing mitral insufficiency. Saphir[8] felt that with subacute bacterial endocarditis, the chordae were affected by direct extension of the infective process.

The diagnosis may be suspected clinically by the abrupt appearance of a systolic murmur, the rapid onset of congestive heart failure, and a discrepancy between the severity of the regurgitation and the modest left atrial enlargement. The apical systolic murmur is always loud. It may be harsh and radiate to the base of the heart, simulating aortic stenosis. However, the murmur is usually not heard over the carotid vessels.

Cardiac catheterization reveals extremely high "V" waves in the pulmonary wedge pressure record. This is usually *not* found in cases of long-standing mitral insufficiency because of the decreased compliance of the left atrial wall over many years; but it *is* seen in situations where the mitral insufficiency has been of a more acute nature.

Because these patients seldom live more than a year after the onset of symptoms, the urgent need for early surgical intervention is apparent. Placement of artificial chordae has been done by Morris.[10] The length of the artificial chordae may be difficult to judge at operation. If after surgery, the left ventricule diminishes in size this may allow prolapse of the artificially anchored leaflet into the left atrium with recurrence of the insufficiency.

Suturing of the free valve edges to the free papillary muscle has also been advocated. Kay[7] has described plication of the mitral annulus with good results in nine of ten patients. With the improvement in prosthetic valves, this appears to be the method of choice today. Prosthetic replacement of the mitral valve was used in all three of our cases. In the first two, a Starr-Edwards prosthetic valve was inserted and in the third, a Kay-Shilley disc valve was used. Our first two patients are now alive and well five years and two years post-operatively. The last patient died four months post-operatively of septicemia and recurrent initial insufficiency due to separation of the prosthetic ring from the mitral annulus.

The final outcome of the last case might have been different had he been subjected to

a reoperation and connection of the prosthetic ring separation without delay, rather than trying to improve his cardiac status by medical means before attempt at surgery. This latter case further demonstrated the futility in attempting to treat a case of acute mitral insufficiency by medical means.

Summary

(1) Three cases of mitral insufficiency associated with ruptured chordae-tendinae are presented.

(2) The etiology, clinical features, and need for early surgical intervention are stressed.

(3) Excision of the remnant of the mitral valve, and replacement with a prosthetic valve appears to be the treatment of choice.

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144 South Harrison Street

Private Sources Spend Less For Health Care

Health care expenditures in the United States have been growing faster than other elements in our Nation's economy. And there has been an increase in the government's share of health costs and a decrease in the share paid by private sources. The private citizen is spending a smaller portion of his personal income for medical costs than he did in 1965.

There are indications, a Social Security Administration report says, "that public health programs are, in fact, taking over some of the burden on consumers for financing the high costs of medical care and are leaving a greater proportion of the consumers' income for other items." Thus in 1929, health care outlays accounted for only 3.6 per cent of the gross national product (GNP) but in 1969 the figure reached 6.7 per cent. This escalation in national health expenditures resulted from a growth in population, higher costs, an increased use of available services and a widened scope of such services through new technics, drugs, and treatment procedures.

Even if cost of living and increased prices were taken into consideration, the amount spent on health needs for each person in the United States in 1968 was more than triple that of 1929. In that year, only $3.6 billion was spent in this country for health care of which 86 per cent was from private sources. In 1968, the figure was up to $57 billion with only 63 per cent from non-public funds.

In 1929 the average consumer paid 3.5 per cent of his disposable personal income for health purposes. The figure gradually rose to 6 per cent by 1965, but by 1968 had dropped to 5.6 per cent. Private insurance payments in 1965 represented 43 per cent of hospital expenditures but in 1968 only 35 per cent.

The association between tic douloureux and diabetes is a bit too frequent to be mere chance, yet the relationship is not scientifically established.

Trigeminal Neuralgia And Diabetes Mellitus*

Albert J. Finestone, M.D.; Mohamad Choudhry, M.D.; and Henry A. Shenkin, M.D./Philadelphia

Trigeminal neuralgia is characterized by recurrent intense lancinating pain in one or more regions supplied by the fifth cranial nerve. Neuropathy is a common concomitant of diabetes mellitus. Clinically, sensory symptoms predominate with abnormal sensations including hyperalgesia commonly being present. The etiology of trigeminal neuralgia is obscure. More information is available on diabetic neuropathy, and important biochemical abnormalities and vascular abnormalities have been found in nerves affected.

One of us has been impressed with an apparent high incidence of diabetes mellitus in patients with trigeminal neuralgia. However, it might be pointed out that patients with this combination are called to his attention by the neurosurgical service of this hospital. The only other disease related to trigeminal neuralgia has been multiple sclerosis.[1] Nonetheless it was felt worthwhile to explore the possible relationship by a retrospective study of the last 92 cases of trigeminal neuralgia seen at Episcopal Hospital. Collis and Wallace[2] have recently studied 30 patients with trigeminal neuralgia from the Cleveland Clinic and found 10 patients with abnormal glucose tolerance.

All charts were classified into three categories; definite diabetes, non-diabetic, and suspected diabetes. Patients were considered to be diabetic using the following criteria: known diabetes under treatment; diabetic glucose tolerance curve. In five patients fasting blood sugars were over 155 and these were also placed in the diabetic group. Suspected diabetics were so classified if glycosuria or fasting or postprandial blood sugars were slightly above normal. The non-diabetics had no glycosuria and normal fasting or postprandial blood sugars.

The series was divided in groups by decades. Trigeminal neuralgia is known as a disease which rarely starts before the fifth decade of life. The following table demonstrates this.

Ages	*Number of patients*	*Suspected Diabetes*	*Diabetes*
25-34	1	0	0
35-44	7	1	1
45-54	15	3	0
55-64	26	5	3
65-74	20	6	4
75-84	20	6	3
85-94	3	0	1
	53 Female		39 Male

Females predominated in the series. Twelve of the 92 cases were definitely diabetic and 21 suspected diabetic patients were found. In the age groups from 65 to 84, there were 40 patients with an incidence of almost 50 per cent (19 patients) who either had diabetes or suspected diabetes. The 21 cases of suspected diabetes illustrated the problems of a retrospective study. Some of these patients may have diabetes but unfortunately the information available from the chart was not sufficient to resolve this problem. The effects of increasing age and possible dietary impairment due to pain on glucose tolerance fur-

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ther complicated this matter. Nonetheless it was felt that some of the patients in the suspected category probably did have diabetes. Finally, eliminating all of these suspected cases would still leave a higher incidence of diabetes among the patients with trigeminal neuralgia. In the age group 66 to 74, the Public Health Service estimates a rate of 53 cases of diagnosed diabetes per thousand and 26 cases of undiagnosed diabetes per thousand. In the age group 75 and over, the rates are 51 diagnosed cases per thousand and 24 undiagnosed cases per thousand.[3]

More fully to delineate this possible relationship it would appear that there should be a careful evaluation of carbohydrate tolerance in every patient with trigeminal neuralgia. Collis and Wallace[2] also suggest that "patients with tic douloureux whose status in regard to diabetes mellitus is not known, be given glucose tolerance tests to establish the presence or absence of diabetes mellitus." Our present study is a clinical observation of interest but we realize that the observations are not sufficiently clear to establish a firm relationship between diabetes and trigeminal neuralgia.

Summary

In a retrospective study of 92 patients with trigeminal neuralgia, 12 were definitely diabetic and 21 were suspected to have diabetes. In the 40 patients ages 65 to 84, 19 were either diabetics or diabetic suspects.

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3701 North Broad Street

Anti-Hemophilic Factor

A high potency concentrate of antihemophilic factor (AHF) for the prevention or control of bleeding in victims of hemophilia, has been developed by the American Red Cross under a research contract awarded by the National Heart Institute.

This new concentrate contains some 50 to 100 times as much AHF as does an equal volume of whole blood or plasma. It is prepared from blood plasma, and it can be processed to yield albumin, gamma globulin, and other plasma proteins.

The AHF concentrate is stable and can be stored at refrigerator temperature for prolonged periods. Its high purity minimizes the risk of side reactions. It will be some time before the concentrate becomes available in quantity. However, the new precipitation technic will make quantity production of AHF feasible.

The coagulation defect of hemophilia A can be corrected only by making good the AHF deficit, and the correction is only temporary. Infused AHF disappears rapidly from the blood; its normal half life is only about 10 hours.

Until only a few years ago, AHF could be supplied to the hemophilic patient only by transfusions of freshly drawn whole blood or fresh or freshly frozen plasma.

In all the world's medical literature there are only 66 documented cases of primary melanoma arising in the meninges of the cord. Here is another such case.

Primary Melanoma Of The Leptomeninges Of The Spinal Cord

A Case Report And Review Of The Literature*

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Salvatore J. Emanuele, M.D./Edison
A. W. Sami, M.D./Paramus

Primary malignant melanoma arising in the leptomeninges of the spinal cord with minimal involvement of the brain is extremely rare. Virchow[1] in 1859 described the first case of primary melanoma anywhere in the central nervous system. Excluding simple melanosis (and those associated with skin nevi which occur in children[3]), there have only been 66 additional documented cases[4,5,6,7] since that time. Only 26 of these showed predominant spinal cord and minimal brain involvement. This is another case report with unusual presenting signs and symptoms.

The patient was a 56 year old female admitted to the hospital on November 26, 1968 because of pain in the right costal and subcostal regions. Two days prior to admission she had recurrent nausea and vomiting accompanied by epigastric pain radiating to her back. Before this illness her health had been good with no hospitalizations or operations. Her mother died of carcinoma of the lung at age 71 and a sister died of carcinoma of the breast at age 46. A living brother age 60, has a grade I transitional carcinoma of the bladder.

She was a well nourished, well developed female in apparent pain. Her pupils were round and equal, and reacted to light. No nystagmus was present and careful examination of the fundi showed normal blood vessels and no exudates, hemorrhages, or tumors. The carotid pulses were good and the trachea was in the midline. The lungs were clear to percussion and anscultation and the heart had a normal rhythm with no murmurs. Palpitation of the abdomen revealed right subcostal and epigastric tenderness but no masses or enlarged organs. There was no edema, cyanosis, or clubbing of the extremities. No Hoffman or Babinski sign was present. Our impression was "gallbladder disease with possible secondary pancreatitis, peptic ulcer or gastrointestinal tumor."

A neurologist found an area of decreased sensation to pin prick in the right abdomen. Her abdominal reflexes were absent. Straight leg raising was restricted by pain.

Laboratory results included a hemoglobin of 13.4 Grams per cent, hematocrit of 40 per cent, a white blood count of 10,100 and a differential of 82 neutrophils, 12 lymphocytes, and 6 monocytes. Urinalysis was normal and three examinations were negative for Bence-Jones protein.

Gastrointestinal x-ray series revealed no abnormalities. A cholecystogram showed good concentration of the dye with no stones. X-rays of the dorso-lumbar spine were partly obscured by intestinal contents but no abnormalities could be demonstrated. Roentgenograms of the chest, a barium enema, and an intravenous pyelogram were also negative.

On December 15, 1968, a myelogram was done. The lumbar puncture yielded clear yellow spinal fluid. X-rays showed an obstruction to the opaque dye at the level of the tenth thoracic vertabra. A small amount of dye passed beyond the obstruction revealing displacement of the spinal cord to the right. The defect was smoothly marginated and the radiographic impression was "an intradural, extramedullary tumor such as a neurofibroma or meningioma."

Examination of the spinal fluid revealed protein of 107, sugar of 25.4, and chloride of 116. Cell count showed four neutrophils, 47 lymphocytes, and 461 red blood cells. In view of the findings on myelography and spinal fluid examination, a laminectomy at the level of T-9 and T-10 was done on December 21, 1967. An intradural extramedullary black tumor was encountered which compressed the cord and the nerve roots at that level. By frozen section, pieces of the

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tumor were diagnosed as malignant melanoma. The posterior and lateral portions of the tumor were removed despite their adherence to the spinal cord, nerve roots, and dura. Some of the tumor on the anterior surface of the cord could not be removed because of adherence to the bone and soft tissue. Closure of the dura, muscle, fascia, and skin was performed. The pathologist's report follows:

The specimen consisted of several pieces of soft black tissue, the largest measuring 1.2 by 1.0 by 0.6 centimeters. Microscopic examination showed cells with round or oval nuclei and eosinophilic cytoplasm containing large amounts of dark brown or black pigment. The nuclei showed moderate hyperchromatism and pleomorphism with occasional mitotic figures and macronucleoli. There were some bizarre tumor cells. Focal lymphocytic infiltration was noted. The final diagnosis was malignant melanoma.

The patient did poorly postoperatively suffering back pain and refusing to eat. The operative incision healed well but food intake continued to be minimal with occasional vomiting. On January 26, 1969, two months after admission, she died.

Careful postmortem examination of the skin revealed neither pigmented lesions nor scars where such lesions might have been removed. The healed operative scar on the back measured 12 centimeters. The nasal and oral cavities and the vulva and vagina were also free of pigmented lesions. The mediastinal lymph nodes were enlarged with areas of necrosis. The lungs showed marked bronchopneumonia. The gastrointestinal and genitourinary tracts were free of tumor. No lesions were found in the spleen, liver, pancreas, or adrenal glands. The entire spinal cord with its meninges was removed anteriorly. Black pigmentation of the dura and cord was seen (Figure 1). At the level of T-9 and T-10, the dura was adherent to the spinal cord and there was recurrent growth of the tumor (Figure 2). In some areas the tumor was gray and rubbery with no pigmentation while in other areas it showed deep black pigmentation. Serial sections of the dura and cord disclosed spread of the tumor to all levels al-

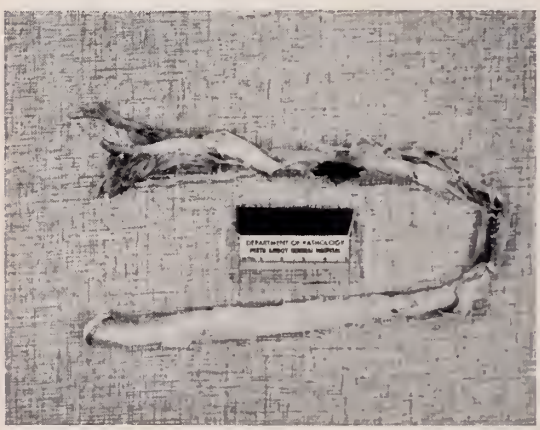


Figure 1—Spinal cord and dura with hyperpigmentation and tumor

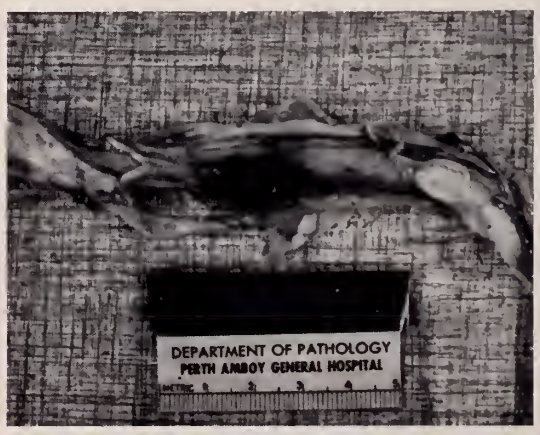


Figure 2—Spinal cord and dura with hyperpigmentation and tumor at T-9—T-10



Figure 3—Transverse sections of spinal cord and dura at various levels

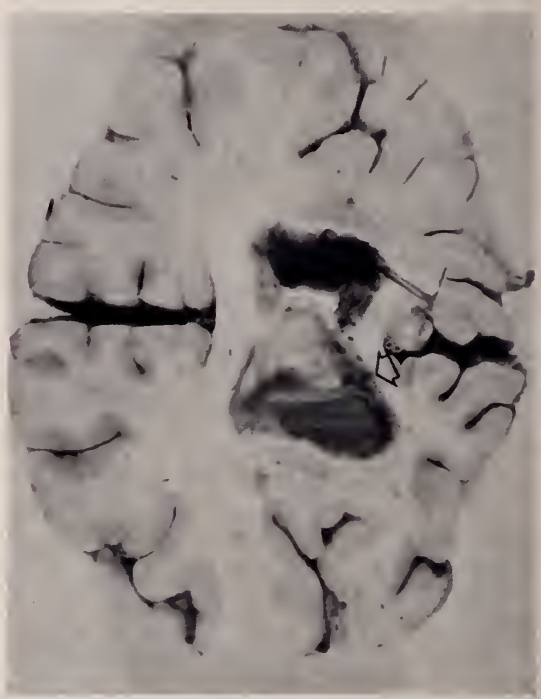


Figure 4—Small pigmented tumor implants on ependymal lining of lateral ventricle

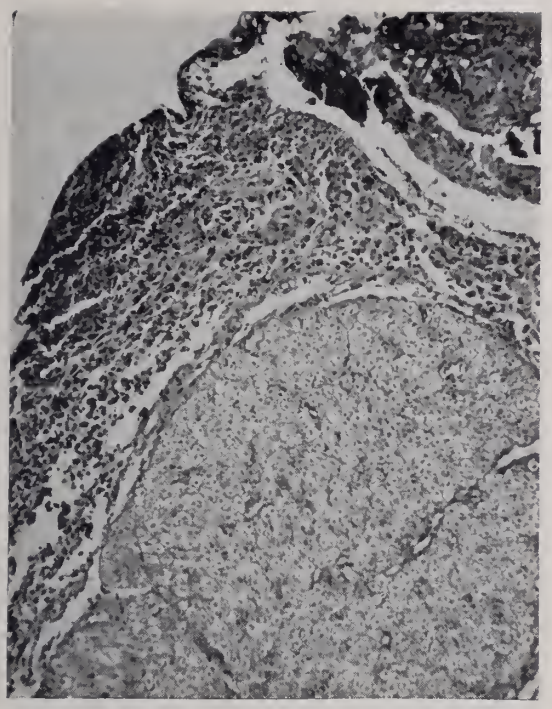


Figure 5—Nerve root compression by tumor cells at T-10

though the greatest amount of tumor was present at T-10, 11, and 12 (Figure 3). At these levels the tumor invaded the posterior surface of the spinal cord and compressed nerve roots.

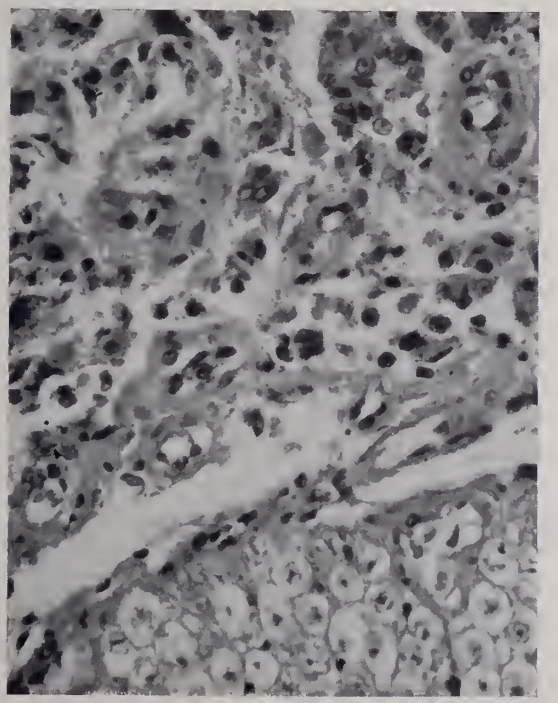


Figure 6—Nerve root compression by tumor cells

Involvement of the brain was limited to small tumor implants in the ependymal lining of the lateral ventricles (Figure 4). The microscopic findings were similar to those found on the surgical specimen where there was tumor infiltration of the brain and spinal cord (Figure 5) which was superficial. Tumor cells surrounded and compressed the nerve roots (Figure 6 and 7). The cells varied in pigment content from none to fine brown to coarse brown granules. Final diagnoses were malignant melanoma, meninges of spinal cord with metastases to the brain, and bronchopneumonia.

Cells which contain melanin are normally present in the iris, ciliary body, and retina of the eye, adrenal glands, carotid body, the meninges, and the substantia nigra, in addi-

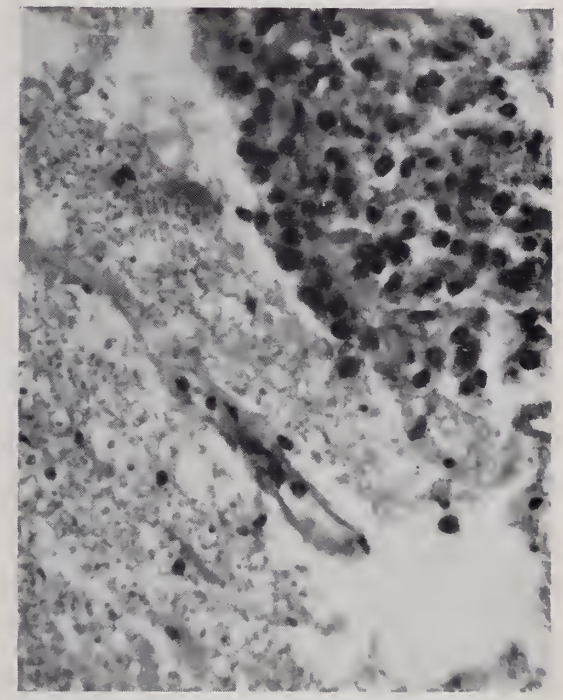


Figure 7—Infiltration of spinal cord by tumor cells

tion to the skin. Their incidence in the leptomeninges of the brain and spinal cord in a study by Roco de Vinals *et al.*[8] was 85 per cent. He reviewed 100 cases. In Ravens' study[12] they were found in greatest numbers from T-4 to T-8, in smaller numbers from T-2 to T-5 and rarely from T-8 to S-6 (Figure 8 A, B, & C).

That only tissue with elements from the neural crest can produce pigment in mice was shown by Rawles[9]. Since these elements migrate to the skin, eye, and meninges, this

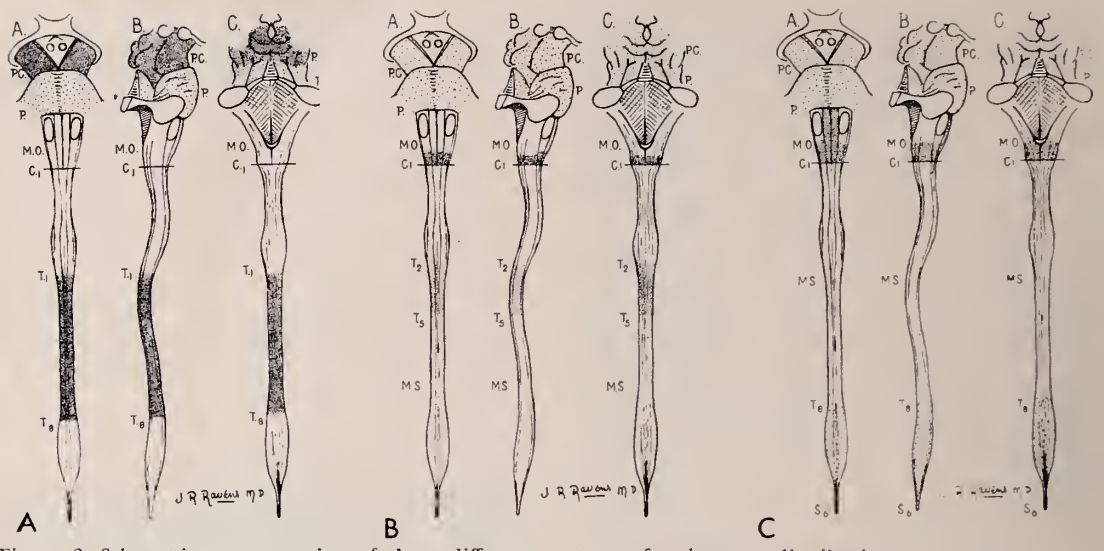


Figure 8—Schematic representation of three different patterns of melanocyte distribution

explanation for the origin of melanosis and melanomas of the meninges, i.e. from neural crest elements avoids the controversy of whether they are ectodermal, mesodermal, or neurogenic in origin.

Virchow[1] considered his case to be a melanosarcoma which had arisen in a diffuse hyperplasia, i.e. melanosis. Bouton[10] also came to this conclusion on the basis of Touraine's analysis[2] of 58 pigmented tumors of the meninges. Seventeen of the 27 which were malignant, (i.e. invaded the cord or were disseminated) also showed diffuse melanosis while the other 31 cases were benign (simple melanosis). Half of the cases also showed abnormal skin pigmentation which was not present in our case. Most authors exclude from their series cases which show visceral metastases, on the basis that they are probably metastatic from another primary site.

Hirano and Carton[6] reported one case of melanoma of the cord and reviewed 25 from the literature. The ages of these patients varied from 25 to 71 with a median of 49. There was an equal sex incidence. Chief complaint in 21 of these 26 cases was pain, which was frequent and severe, and sensory loss in the lower extremities. A level of the lesion could be determined by neurologic examination in 21 patients. Sphincter involvement, paraparesis, paraplegia, tetraparesis, and tetraplagia were found less frequently. These signs and symptoms can be explained by compression of the nerve roots and spinal cord by tumor. One of Tolnai's two patients[7] had nausea, vomiting and anorexia. A case of Fasske's[11] had the initial symptom of vomiting, and Hirano and Carton's[6] patient had constant pain in the left flank. Abdominal pain (RUQ) with nausea and vomiting which occurred in our case, was distinctly unusual. Only one patient showed erosion of the vertebral pedicle on roentogenogram of the spine. Myelography was abnormal in 9 of 10 patients showing a complete block in seven patients and defects in the other two. Fifteen of 17 patients showed spinal fluid abnormalities including xanthochromia, elevated protein concentrations and pleocytosis.

Removal of the tumor was attempted in 14 of 19 patients and was reported to be complete in only 4 cases. Death occurred within a few days of the operation in two of the four and in a third case, in six months. The fourth patient was alive at the time of the report, but the time period following the operation was not given. Radiation was ineffective although five patients improved following therapy for a short time. Patients with this diagnosis therefore have a uniformly poor prognosis with short postoperative survival. Im-

proved survival rates are theoretically possible if the disease is diagnosed in its "premalignant" stage i.e. simple melanosis by spinal fluid examination including Papanicolau smears and biopsy of the meninges. If melanosis is diagnosed, resection of the involved meninges might be performed.

Summary

A case of primary malignant melanoma of the leptomeninges with autopsy findings in a 56 year old female is reported. The tumor predominantly involved the spinal cord and to a minimal extent involved the ependymal lining of the lateral ventricles. No tumor was found in any visceral organ or in the usual sites of primary melanomas. The patient presented with the unusual symptoms of sharp right-sided subcostal pain, nausea, and vomiting, thus resembling an intraperitoneal disease process. Careful neurologic examinations were necessary to elucidate the true cause of these symptoms. The finding of melanotic cells on examination of the spinal fluid in any patient with sensory and motor loss in the extremities should suggest simple melanosis or melanoma of the leptomeninges and laminectomy is indicated. Although the prognosis is extremely poor for melanomas, focal melanosis might be treated by segmental resection.

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530 New Brunswick Avenue (Dr. Becker)

Kick The Habit Campaign

The Tuberculosis-Respiratory Disease Association is inviting you to call your patients' attention to the "Kick The Habit" campaign this month. Although 21 million Americans have already quit smoking, this campaign will be aimed at the 70 million who continue to smoke even though the hazards, the cost, the nuisance, and the physical dangers are well-known. Remind your patients of the advantages of becoming a non-smoker. A non-smoker breathes more easily, feels less tired, and has more energy. His circulation improves and his body can better defend itself. Trying to kick the habit is easy. All it takes is practice and a positive attitude. One in every three persons who tries to quit succeeds in doing so. Your New Jersey Tuberculosis-Respiratory Disease Association has information available on the benefits of not smoking. They also have two leaflets, *Me Quit Smoking, Why?* and *Me Quit Smoking, How?*, which provide the assistance many smokers need in order to kick the habit. Write to the New Jersey Tuberculosis-Respiratory Disease Association at 2411 Route 22, Union, New Jersey 07083.

Neurolept, a new approach to anesthesia and analgesia, has some advantages—but also, as here detailed, some liabilities too.

Neurolept Analgesia*

Henry A. Connolly, Jr., M.D./Summit

A new development in anesthesia is "neurolept analgesia." The available drug for this purpose is Innovar®, a McNeil tradename for a combination of fentanyl (Sublimaze®) and droperidol (Inapsine®). Neurolept analgesia has been used clinically and extensively throughout Europe since it was first introduced in 1962 by Mayerhofer. It originated with the development of the neurolept (which is simply a tranquilizer) by the French scientists, DeCastro and Mundeleer[1], in 1959. Janssen[2], in 1958, synthesized this narcotic (analgesia). The Innovar® combination is named neurolept analgesia (NLA). It is a combination of the neurolept-droperidol (Inapsine®) with the analgesia fentanyl (Sublimaze®).

Droperidol and fentanyl combined work as an anesthetic and may be administered intramuscularly or intravenously. The intramuscular route is used especially for premedicating the patient. Intravenous administration is the means of induction and maintenance of the anesthesia. Advantages of this type of anesthesia are stability of the cardiac vascular system, its non-explosive quality, good analgesia, relative lack of vomiting or nausea in the post-operative phase, and rapid return to consciousness. Liver and kidney functions do not seem to be influenced or interfered with. The poor risk, debilitated, and geriatric patients appear to do very well with this type of anesthesia. These patients have been noted to require less pain medication for the first 6 to 8 hours.

The disadvantage attributed to the analgesic fentanyl is a certain degree of respiratory depression which may require assisted or controlled respirations. It may even necessitate intubation. The "Frozen Chest Syndrome" can be readily corrected by succinyl choline, a muscular relaxant. Fentanyl in itself is a narcotic and chemically related to meperidine (Demerol®). It is 75 to 100 times more potent than morphine. The antidotes are levallorphan (Lorfan®—Roche) and nalline. Another disadvantage is the relatively slow intravenous induction period. There is also the need, in many cases to induce and maintain sleep with nitrous oxide and oxygen, along with the titration of Innovar®.

Droperidol has a long acting duration (6 to 8 hours) effect. It has the ability to potentiate any tranquilizer, barbiturate, or narcotic which might be given to the patient. This neurolept analgesia is a relatively poor anesthetic in children under 10 years of age, primarily on the basis of the erratic responses of children to any narcotic or tranquilizer.

Innovar® has a wide field of usefulness both surgically and diagnostically, especially in plastic surgery, and in otolaryngologic, abdominal, gynecologic, and orthopedic procedures. Innovar® is contraindicated in obstetrics.[3]

The dosage of a cubic centimeter of Innovar® mixture is droperidol 2.5 milligrams and fentanyl 0.05 milligrams. Innovar® 0.5 to 2 cubic centimeters are administered intramuscularly for patient premedication. The usual intravenous induction dose is calculated on the basis of one cubic centimeter per 20 to 25 pounds of body weight. For the older or poor risk patients the reduced intravenous

*Presented at the clinical workshop on neurolept anesthesia on April 26, 1969. Dr. Connolly is chief of anesthesia at the Overlook Hospital in Summit, where this seminar was held.

induction dosage of 0.5 cubic centimeter per 20 to 25 pounds is recommended. Total anesthesia dosage of 4 to 5 cubic centimeters intravenously is the average amount used and lasts for about 45 minutes. The induction dose should be administered slowly over a 3 to 5 minute interval. During this time careful assessment of the vital signs is indicated. For maintenance of anesthesia 0.5 to 1 cubic centimeter may be given in response to the surgical stress.

Innovar® may be classified as relatively long acting and provides us with a patient who is indifferent, analgesic, and hypomotile. Innovar®, whether alone or combined with nitrous oxide and oxygen and muscular relaxants in anesthesia, can provide a broad range of safe anesthesias for diagnostic and surgical procedures.

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159 Mountain Avenue

The Heroin Flow

The federal government has just negotiated new agreements with France and Turkey aimed at stemming the flow of heroin into this country. John E. Ingersoll, Director of the Bureau of Narcotics and Dangerous Drugs, has explained that the Government's long-range objective in dealing with the problem is "to induce the medical community to find adequate substitutes" for opium, from which heroin is derived. Ingersoll reported that the U.S. was asking a great deal of Turkey where opium has been grown for centuries.

"But when you have over 900 deaths from heroin (224 of them teenagers) in one city, I think you've got a right to start hollering," he said. "There were three deaths a day from heroin in New York City in 1969. It is the major cause of death for 18 to 35 year olds in New York City."

Ingersoll estimated that 80 per cent of the three tons of heroin smuggled into the U.S. annually comes from the poppy fields of Turkey *via* the clandestine laboratories of France where the opium is refined into heroin.

The agreement with Turkey includes a $3 milion loan which had been approved by the agency for international development in 1968. The money is to be used partly to help the Turkish citizens substitute crops like sugar beets and sorghum for opium and partly to equip and train a 460 man narcotics police force.

The U.S. agreement with France calls for frequent meetings to exchange information on such matters as the known drug traffickers and trafficking routes.

France has also assigned a force of 300 police to fight narcotics internally and 30 police to combat it at the international level. Ingersoll's narcotics bureau will increase its manpower in France and also will engage in a cross-training program with French police.

Tybamate apparently offers hope of satisfying some of the cravings of the heroin addict, without getting him hooked on the substitute drug.

Nonaddictive Psychotropic Medication For Imprisoned Narcotic Addicts*

Harold S. Feldman, M.D./Livingston
Michael M. Mulinos, M.D./Westfield

Tybamate is a tranquilizer chemically related to meprobamate, therefore potentially open to the development of dependence and abuse. Its liability to these effects was determined by us and others, with no earlier evidence that these dangers existed. The abuse of drugs acting on the central nervous system is a matter of historical record attesting to the necessity for the fulfillment of certain human emotional needs which society has not succeeded in satisfying. Under the stresses of today's society, interest in the growing problem of drug abuse ranges from morbid dramatizations of the addict's life to futile legal restrictions on his habits, all of which infers a high rate of addictiveness to most of the newer psychotropic drugs as well as to the established narcotic staples. The psychic defect responsible for the "drive" which leads to the abuse of drugs (and the development of dependence) remains poorly understood. The development of drug dependence almost always reflects some form of underlying mental disorder which precedes taking of drugs and predisposes the subject to drug abuse.[1]

Acceptance of and experience with this concept has enabled medical efforts to be concentrated on means of reducing or satisfying the needs of drug addicts by use of other drugs that are not so intrinsically harmful. The successful replacement of heroin with methadone is a case in point. But the present controversy over the use of methadone as a substitute for heroin suggests that it would be more satisfactory if the substitute were not addictive itself. The danger of development of emotional and physical dependence to drugs such as analgesics, tranquilizers, and others (in addition to the true narcotics) is greatest among individuals with a propensity to addiction. The prospect of developing a drug useful in treating drug-dependent "addicts" logically begins with the determination of the addictiveness to the drug in question.

Plan of Study

Tybamate (2-methyl-2-propyl trimethylene butylcarbamate) is related to meprobamate in chemical origin and tranquilizing activity. Direct attempts[2] have failed to produce evidence of psychic or physical dependence to tybamate following prolonged administration of high doses to animals or humans.[3 to 6] This property suggests its immediate advantage over meprobamate, chlordiazepoxide, and diazepam in this respect.[7 to 12]

This is part of a continuing study of known drug addicts of the nonaddictive property attributed to tybamate through well con-

*This work is from the Essex County Penitentiary at North Caldwell (New Jersey). The medication and placebo were furnished by Wallace Pharmaceuticals of Cranbury, New Jersey. Dr. Feldman is Director of the Quinn Rehabilitation Program for Addicts (at the Essex County Penitentiary), and Dr. Mulinos is the Consultant in Pharmacology. Dr. Feldman is Assistant Professor of Psychiatry at the New Jersey College of Medicine and Dentistry, and reprint requests should be directed to him at the College, 24 Baldwin Avenue, Jersey City, New Jersey.

trolled animal studies[2] and certain human populations.[3 to 6] In a previous communication[3] we described our findings in a group of psychotic patients who were treated for several weeks with tybamate in daily doses up to 4 Grams. No signs of withdrawal symptoms or evidence of tolerance developed when the tranquilizer was replaced abruptly with a placebo, indicating the absence of drug dependence as defined by the World Health Organization.[13] Tybamate tended both to quiet overactive patients as well as to evoke responsiveness from long-detached schizophrenics, with resultant over-all improvement in cooperation on the wards. There were no adverse somatic reactions which were not readily reversed. Although mood seemed generally improved, neither tolerance to the drug's action nor euphoria was apparent at that time.[3]

The use of psychotic patients in the original study was predicated first, on the belief that a tranquilizer such as tybamate would greatly benefit them and second, that it was important to establish what degree of dependence liability existed in such a clinical population. Encouraged by the absence of evidence of emotional or physical dependence on tybamate, we corroborated this lack of dependency through the use of a group of known drug addicts, as detailed below. In addition, we wished to evaluate the effectiveness of tybamate in controling the addict's desire for the heroin upon which he had become dependent, by using a tranquilizer which itself was not addictive. Forced abstinence and the penal enclosure were factors expected to aggravate the subjects, making it easier for them to succumb to any habit-forming drug, however mild its tendency to dependence.

Tables 1 and 2 present the results of the administration of increasingly large daily doses of tybamate to imprisoned heroin addicts in an attempt to satisfy their expressed desire to maintain their freedom from the use of narcotics upon discharge from the prison. The objective was twofold: to confirm and elaborate upon our previous findings that tybamate does not induce drug dependence[3] and to evaluate its effectiveness in reducing the overwhelming desire for the narcotic experience.

Methods

Twenty-eight male inmates of the Essex County (N.J.) Penitentiary, all having experienced other detoxification procedures following heroin addiction, volunteered† to take part in the study. No reward was promised or given other than the increased hope of assistance in breaking the narcotics habit. The 24 male inmates who actually entered the study included eight Negroes, and two Puerto Ricans. Average age was 25 (range 19 to 34); average weight was 73.5 kilograms.

Prior to the study all subjects were questioned regarding their attitudes toward heroin and its effects. Results of these preliminary taped interviews were later compared with those of similar interviews held during the course of each subject's period of test medication. The Minnesota Multiphasic Personality Inventory was also administered to each subject. Prior to the start of tybamate, periodically during drug administration, and daily for a week preceding its discontinuation, emotional and physical disturbances were looked for and graded as *mild, moderate,* or *severe* for each subject. Physical examinations at the start, during, and end of the study included blood pressure readings (taken two or three times a week from the same arm with the subject standing), heart rate, hemograms, urine chemistry, and tests for liver and kidney functions. Tybamate plasma concentration levels were determined for a number of the subjects from periodic blood specimens.

Medication in the form of tablets containing 350 milligrams of tybamate was administered for uninterrupted periods ranging from one to seven weeks. Tablets were given three times daily at the prison dispensary, where adherence to the proper dosage schedule was enforced by trained counselors who ensured that the tablets were taken in their presence. Starting daily dose was ten tablets, or 3.5 Grams

† Each subject was told about the project and gave written and knowing consent.

of tybamate. Progressively higher doses were given at weekly intervals (Table 1) except when daily inquiries revealed symptoms of excessive sedative activity or troublesome side effects. (Table 2). Doses up to 33 tablets (11.5 Grams) per day had been attained at the end of the seventh week. At this time eight of the ten subjects still receiving tybamate were abruptly switched to a matching placebo for an additional three to seven days of study. No other psychotropic drug was permitted during the period of tybamate administration.

TABLE 1

Weekly Progression of Tybamate Dosage

End of Week	No. Subjects on Tybamate	Average Tybamate Dose Tablets/day* (350 mg.)	mg./Kg/day Range	Av.	Cumulative Gm./subject
1	25	10	48- 51	50	25
2	20	15	61- 91	74	61
3	20	18	94-111	89	105
4	15	20	82-113	97	154
5	12	25	107-133	122	216
6	11	30	129-160	149	290
7	10	33	141-175	164	370
8 & 9	0*	—	—	—	—

*Drug discontinued in all 10 subjects, with placebo substitution in 8.

Results

Table 1 shows the progressively higher dosage levels generally administered over the course of the study and the number of subjects continued each week. Reasons for discontinuation before the seventh week of medication included discharges from prison and (because of the high drug doses used) occasional signs of excessive sedation (Table 2).

TABLE 2

Symptoms or Signs in Subjects Receiving Tybamate

Symptom/Sign	No.	Daily Dose Eliciting Symptom (Gm.)
Improved sleep*	22	3.8-11.5
Slurred speech	9	6.3-11.5
Dry mouth	3	11.5
Syncope	1	7.4
Dizziness	2	7.4
Falling	2	9.4
Sluggish, lethargic	5	7.5-11.5
Uncoordinated	8	7.5-11.5
Irrational	1	7.5
Drooped lids	4	6.3-11.5
Euphoria	4	6.3-11.5
No symptoms†	7	3.5- 7.0

*Prior to tybamate: 7 "poor" and 15 "fair."
†On tybamate: 4 for 1 week, 3 for 3 weeks.

Neither the ten subjects who reached the level of maximum doses nor any of the fourteen subjects discontinued earlier displayed any symptoms suggesting withdrawal reactions or any evidence of psychic or physical dependence on the tranquilizer.

During the week preceding the administration of tybamate all 24 subjects were found to be healthy young men without evidence of disease. Seven were considered insomniacs, while fifteen others had sleep disturbances of lesser degree. Restlessness, agitation, or irritability were manifest in sixteen and depression in seven. Four reported poor appetite, two were classified as autistic, one as uncooperative and defiant, one as slow and sluggish, and one with headaches. Some subjects had more than one type of symptom.

Except for six who were discharged from prison or refused to continue in the study, pre- and post-treatment laboratory values were obtained for each subject. No significant changes appeared in hemograms, urinalyses, or tests for hepatic and renal functions, despite the high and prolonged doses of tybamate used. Liver function test values, in a few cases, were somewhat elevated throughout, probably as a result of infectious viral hepatitis contracted previously through contaminated needles in the self-administration of heroin. Tybamate plasma levels indicated the drug was being ingested as directed.

There were no side effects among the subjects studied which were not ascribable to the tranquilizing effect of the drug (Table 2). In this respect a contrast is evident with the authors' previous study of tybamate.[3] With the earlier group an average daily dose of 62 milligrams per Kg (10 tablets) for an average

of two weeks, there occurred mild to moderate sedation and decreases in blood pressure which forced reduction of doses for 10 of the 21 psychotic patients. In the present group, drowsiness was rarely observed until daily dosage levels exceeded 6.3 Grams (18 tablets). Regular blood-pressure readings showed no hypotensive tendency such as was observed in the previous study. Although doses in the present study averaged 116.1 milligrams per Kilo during two to seven weeks of medication (Table 1), the average blood pressure was essentially unchanged at the end of the study (124/81) as compared to initial values (116/69). No decreases occurred in any subject.

One possible contributing factor to the hypotensive effect in the previous study may have been the acknowledged lability of circulation in older psychotic subjects,[14] rendering them susceptible to psychotropic drugs.[15] Regardless of the explanation for these inconsistent results among two subject populations differing greatly in age and condition, it appears that any serious concern over the effects of large doses of tybamate on the blood pressure is unwarranted.

Although stepwise elevation of the drug's dosage in the present study began at an unusually high level—for purposes of confirming the nonaddictive property of tybamate—it was found that most of the subjects' avowed desire for heroin was lessened before the tranquilizer produced signs of obvious sedation. Comparison of interviews taped before and during test medication showed a definite reduction in the compulsive drive for heroin. The first signs of this dampened desire were generally evinced during the second week of treatment. Whether this benefit was a function of the drug level attained at that point in the study (about 4.5 Grams daily) or of the quality of the medication's effect cannot be definitely ascertained from the present evidence.

Table 2 summarizes our observations on the influence of tybamate during medication, which accord with the evidence of progressively more marked central effects associated with the meprobamate moiety.

Comment

By design, this group of addicts was challenged inordinately in an attempt to elicit the development of tolerance and dependence to tybamate. Dosage of the tranquilizer at the outset exceeded that used previously in psychotic subjects and was increased weekly to several times the maximal dose recommended for routine psychotherapeutic use. The absence of psychic or physical dependence or the development of tolerance indicates that tybamate offers a means by which to influence favorably the psychophysical symptom complex of interim heroin addicts without itself being open to abuse. Sudden cessation of tybamate administration with placebo substitution in eight and without placebo in two of the ten subjects who had received increasing doses to a maximum of 11.5 Grams (157 mg./kg.) daily and a cumulative dose of 370 Grams over a seven week period, afforded unequivocal subjective and objective evidence that the medication was nonaddictive.

In view of the criminal extremes to which the present subjects had been compelled by heroin addiction, it can be assumed that their addictive propensity, based on their personality profile, was generally quite strong. In addition, there is no question that the high doses of tybamate given to these subjects afforded every chance for the development of tolerance, dependence, and withdrawal syndromes. The combination of a predisposition toward a psychic and physical dependence and a high and prolonged dose which could have elicited these reactions, which never in fact emerged, substantiated the authors' earlier conclusion that tybamate is nonaddictive.[3] Our findings indeed suggest that tybamate may be of definite value in reducing the addict's desire for the effects of heroin. Evidence of this value appeared both in the drug's clear alleviation of anxiety, depression and other symptoms of emotional lability, as well as in the spontaneous comments made by the subjects concerning the effectiveness of

tybamate in "taking the edge" off the alleged narcotic compulsion. Moreover, the voluntary continuation of tybamate treatment by many of the discharged inmates seemed to be a significant point; a similar response had not occurred during the investigation of other psychotropic drugs.

Summary and Conclusion

The present evaluation of tybamate was conducted with 24 male post-heroin addicts, inmates of a county penitentiary who had recently been detoxified prior to imprisonment in this institution. The objective was to test the drug for inducement of psychic and physical dependence. The patients' underlying disorders were graded according to pertinent target symptoms, both before treatment and immediately prior to discontinuation of tybamate. All subjects began on a divided daily dose of 3.5 Grams of tybamate, which was increased progressively each week. The data and observations on the 24 subjects support the following conclusions:

1. Tybamate doses ranging from 3.5 to 11.5 Grams daily, (av. 163 mg./kg.) administered for one to seven weeks, resulted in no pertinent overt symptoms other than the moderate to marked tranquilization to be expected from a drug of this type.

2. The degree of tranquilization was proportionate to the dose, attesting to the absence of any development of tolerance. Upon abrupt cessation of medication—with or without a placebo substitution—there were no signs of withdrawal syndrome or any evidence that emotional or physical dependence had developed during drug administration.

3. Laboratory data obtained before and after tybamate administration revealed no evidence of abnormal changes in liver or kidney functions, hemoglobin concentrations, formed elements of the blood, or composition of urine. Despite the use of much higher doses in the present study, careful attention to routine determination of blood pressure failed to reveal the mild to moderate hypotension previously observed by us in psychotic patients receiving smaller doses of tybamate.[3]

4. Treatment with tybamate effected an appreciable rate of relief in symptoms of tension, anxiety, depression, emotional lability, and other signs often experienced by post-heroin addicts. At the second week of tybamate administration, when the daily dose was about 6.3 Grams, we observed a definite reduction in the avowed desire for heroin, before the tybamate dose level had caused evident drowsiness.

5. Results of the present study—although based on observations of addicts forced to abstain from narcotic drugs during imprisonment—encourage us to suggest that an extended, well controlled investigation of treatment with tybamate may profitably be made earlier during the abstinence syndrome, hopefully to facilitate the addict's struggle with withdrawal from narcotics and subsequently to reduce his yearning for them. Such obviously desirable effects would induce a continuing salutary influence on the addict's orientation to his dilemma.

The trade names corresponding to the generic names mentioned in this paper are as follows: Tybamate is Solacen® (Wallace) or Tybatran® (Robins). Meprobamate is known as Milltown® (Wallace) or Equanil® (Wyeth). Librium® is the Roche trade name for chlordiazepoxide.

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445 South Livingston Avenue

A Malpractice Crisis?

A U.S. Senate subcommittee has recently warned that the number of medical malpractice suits probably will increase and "the situation threatens to become a national crisis."

Senator Abraham Ribicoff, chairman of a committee which has been reviewing the federal role in the nation's health care problems since 1967, reported eight conclusions after an extensive staff study. They are:

1. The number of malpractice suits and claims is rising sharply in certain regions of the country. The size of judgment and settlements is increasing rapidly.

2. Most malpractice suits are the direct result of injuries suffered by patients during medical treatment or surgery. The majority have proved justifiable. These suits are a result of a deterioration of the traditional physician-patient relationship.

3. The publicity given to higher malpractice judgments and settlements, based frequently on new legal precedents, is likely to trigger increasing litigation in other states. The situation threatens to become a national crisis.

4. Higher judgments and settlements have resulted in higher insurance rates. These costs, in the form of higher fees, are being passed on to patients, and to federal programs.

5. The rising number of malpractice suits is forcing physicians to practice defensive medicine, viewing each patient as a potential malpractice claimant. Physicians often order excessive diagnostic procedures for patients, thereby increasing the cost of care. Moreover, they are declining to perform other procedures, which in themselves, may entail some risk of patient injury.

6. The lion's share of the total cost of malpractice suits and claims goes to the legal community.

Specialists listed as having "a greater potential exposure to malpractice suits" were general surgeons, orthopedists, neurosurgeons, anesthesiologists, obstetricians, and gynecologists.

If the situation continues to worsen, the report said, the federal government "may have to consider . . . a reinsurance pool to which it would contribute. They should also consider whether medical or surgical injury to a patient is a community responsibility and therefore compensable by the community, and whether it must provide legal aid to the poor to help them seek redress from medical or surgical injury."

Another area of appropriate federal investigation is whether the Government should insist upon more effective regulatory devices over health professionals and health facilities to assure that those who are providing care are competent to do so.

NEW JERSEY DOCTORS' NOTEBOOK

Address of Retiring President*

Nicholas A. Bertha, M.D.

It is with a great deal of humbleness that I stand here before you today. However, I also take a great deal of pride in the fact that you thought sufficiently well of me to elect me as your President for the past year. I have tried my best to justify your confidence in me.

This has not been a particularly easy year. Among other things, many changes have been occurring in the concept as to how medicine shall be practiced in these United States. During this year Medicaid was started in New Jersey and extensive negotiations were carried out between representatives of the Medical Society and those of the various State groups involved. As a result, New Jersey's Medicaid program got off to a good start, and I believe that I can say with assurance that it is probably one of the smoothest running Medicaid programs in the nation. Credit for this is due to the foresight, the thinking, and the ability to communicate manifested by the individuals from our Society, the Department of Institutions and Agencies, and the Prudential Insurance Company, who worked together on the program. Of course all of this would be of no avail if the members of the Medical Society did not cooperate and do their part in carrying out the program.

Medicare is an on-going program that, too, is for the most part very successful in New Jersey. The Prudential Insurance Company should be congratulated upon the excellent job that it has done as fiscal intermediary for Part "B", and The Medical Society of New Jersey should in turn be congratulated for the excellent job it has done in cooperation with the Prudential Company. The fact of the matter is that as a result of the fine program that has been operative in New Jersey, the Prudential Insurance Company has been named fiscal intermediary in several other states of the eastern seaboard. There will be, as there have been, problems and points of disagreement about both programs, but as long as the present atmosphere of understanding and cooperation continues, the outlook is good.

The Presidential office necessitates considerable time in travel, in visiting our component medical societies, in meeting with other organizations, in legislative procedures, in conferring with governmental agencies, and in visiting medical societies in neighboring states. I have kept a log of the mileage that I have recorded during this year and of the number of hours that I have spent in doing my work as President. I did this because many members asked, from time to time, how much time I lost from my practice or what problems I had in keeping up with my practice and taking care of my patients. The answer is simply that the time and travel required are not so great that one cannot readily afford them. As far as difficulty with patients is concerned, there is little or none—since many of the patients of the doctor who has been elected president recognize that a special honor has been bestowed upon their physician, and they are proud to claim him as their own. Inevitably there are times when the duties of the presidential office will interfere with the incumbent's practice, but matters can generally be so arranged that this interference is minimized.

Those of you who have heard me throughout the year know that there is more to my keeping a log of the time that I have spent away from my practice than just to report it to the House. One of the chief reasons is that I am particularly interested in getting the young members of our profession to come into the family of organized medicine and to take part in its councils and activities. It is my sincere

* Presented before the 1970 House of Delegates, MSNJ, second session, Sunday, May 17, Atlantic City.

belief that young men should hold county offices while they are in their forties, and they should move into action at state level in their late forties, so as to be in line in their mid-fifties for presidential or Board duties in The Medical Society of New Jersey. If they wish to pursue their careers further in organized medicine, they should serve as AMA delegates or alternates and continue there until they are in their mid-sixties.

Personally, I feel very strongly that in the AMA there should be a limitation of length of service and that there should be a retirement age, both for the Board of Trustees and the other officers, and that that age should be 65, just as it is in all big business. Immediately some will say, "Look at the old men who are in Congress." I can answer, "There are exceptions; there are men who retain their physical and mental abilities far beyond the age of 65, but they are few and far between." If the medical profession is going to continue to be strong and progressive, it is going to need the thinking and guidance of younger members who are able to foresee the future and to determine what they desire their practice to be like in that future. It cannot be well served by men and women of fixed ideas whose only vista is retrospective.

As we all know, the profession of medicine at the present time is being harried from all sides. It is being beaten down by numerous small but vociferous groups of people, all of whom are trying to attain an advantage over others and to take over the profession. Why should we in medicine bow to a group of self-anointed, dictatorial economists who are going to tell us how, where, and by what methods we should practice medicine? It is perfectly true that at the present time individuals of this type seem to have the ears of government officials and do influence their thinking and decisions. It is also true that a great deal of influence seems to be wielded by the proponents of group practice, a type of practice very prevalent in the far and middle west. However, why should they be allowed to dictate to us and tell us that we cannot have our own solo or partnership private practice of medicine? Who are these people who say that the practice of medicine deteriorates if it is carried on by solo physicians? Many of these new "authorities" are economists or hospital administrators or academicians or physician administrators, who have never been in the practice of medicine and have never actually taken care of a patient in their offices or in the patient's home. How are they qualified to decide whether or not good medicine can be practiced by the solo practitioner in his office and in the patient's home? Certainly such people are impressed by batteries of tests—all of them expensive—but what they fail to realize is that much good medicine can be, and has been, practiced by experienced, well-trained solo practitioners.

"Quality medical care" is another item frequently referred to. What is quality care? Who can define it? What is it made up of? Is it made up of diagnostic tests? Does it consist of diagnosis or of the treatment of the patient? Is it the art of medicine or is it the science of medicine? Just exactly what is it? Who is to decide on the quality of care? If care must conform to standards, what are those standards, and how are they arrived at? I have been posing the question as to what constitutes quality medical care to many of my colleagues. One of them came up with a definition which I think probably fits better than any other that I have come across. He offers, "Quality care is that care that is medically acceptable, professionally good, and patient-oriented."

I think it is high time that somebody, somehow, somewhere is able to get across to the officials in the government in Washington that quality care is measurable in more than just scientific tests and accurately detailed diagnoses, that the patient demands not only that the cause of his disease be determined but that he be treated promptly and relieved of his pain and discomfort. It is of no value to have a diagnosis and not treat the patient. The patient comes to you first because he is sick or is in pain. He wants relief. While you are affording him that relief, then you

may proceed to evolve the full and accurate diagnosis.

One of our problems in the present day of practice is that physicians are no longer practicing medicine in a manner that they feel is proper for the care of the patient, but they are also at pains to practice in a way that they feel will afford the patient—or his attorney—no basis for starting legal procedures. This was not the situation in the past, but nowadays it is very common. Now as a physician treats his patient, in the background of his mind there always lurks the fear of potential malpractice litigation brought unless he is ultra-careful.

Among the prime reasons for the frequency of liability actions—and one that we as physicians *can* control—is loss of rapport with the patient, who finds that he no longer has confidence in the physician who is treating him. What is responsible? Was it something the physician did or did not do? Was it something that the physician said or did not say? Each physician must remember that he should treat every patient as he would like to have some physician treat him. He must remember to practice his art; science is not enough. I firmly believe that the number of liability suits in this country against physicians would be greatly reduced if each physician would spend just a little bit more time with each patient and treat him more as a human being than as a specimen, a problem, or a commodity. It is better humanely and professionally to leave the patient with some hope that he will get better as you relieve him of his pain and suffering than it is to make a commendable scientific diagnosis and to treat the individual as if he were a mere number. It should be our goal to do all things well. Not only is the patient affected by inconsiderate treatment but his family and friends are also. They all become sharers in generated resentment. They encourage the patient to seek some form of redress.

One of the subjects adding to the controversies going on in the medical profession has to do with the number of students being graduated from the medical colleges. I believe the solution is in the hands of the medical school authorities if they wish to act. If they do not wish to act, I feel that there should be some form of legislation enacted which will make them act in proper manner to increase the size of their classes. In 1932 when I was graduated from medical school there were 115 members in my class. The school, physically, at that time was quite small. The faculty was quite small, and we had a great number of clinical professors. Since that time the school has expanded to five or six times what it was. The faculty is five or six times more numerous, though the clinical faculty has been decreased—a sad loss. But the number of students graduated each year is now only 125 . . . an increase of only 10 graduates in 37 years! Why should not this medical school and other medical schools double the number of students being graduated each year? If every medical school in the United States doubled its classes for the next 10 years it seems to me that the problem of shortage of physicians would be effectively solved. The solution would be achieved without dependence upon paramedical personnel, who may or may not be well-trained, and who may or may not be able dependably to take care of the sick.

Furthermore, I believe that the medical schools, instead of trying to graduate many who are going into research or specialties, should turn their attention to graduating general practitioners. Rather than starting the students into residency as soon as they graduate from medical school and providing such residency as internship, it would be far better, in my opinion, that they be given the opportunity to do a general internship for one or two years. Following the plan started in the Province of Ontario, Canada, these students would then do general practice in small communities and in the ghetto sections, with the government guaranteeing them an income for the first two or three years. Having done this, those students who after two or three years thus spent decide they want to go into specialties should be permitted to go into residencies. The time that they have

spent in doing their general practice should be considered as part of their five year term in residency. There would be no loss of residency time and no loss of research scientists, but there would be a great gain in the number of practitioners that we would have in the United States.

I have enjoyed this year as President of The Medical Society of New Jersey, and I shall always cherish the memories of it. I shall always remember the visits that I made to our component medical societies and the men and women whom I met there. Now I have reached the end of the line. I have reached the turntable; the trolley is now about to turn around, and you are to have a new motormen-conductor combination. Dr. Satulsky is an excellent man. I think you chose wisely when you elected him. I wish him all the success and happiness that I derived from this office . . . May God bless all of you!

Trustees' Minutes

April 19, 1970

A regular meeting of the Board of Trustees was held on April 19, 1970 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Medicaid Peer Review Committee . . . Agreed to the suggestion of the Division of Medical Assistance and Health Services, NJIA, that there be established a Medicaid Peer Review Committee. (This Committee would be composed of members of MSNJ, who would be paid a per diem by New Jersey Medicaid Plan.)

. . . Agreed to submit suggestions for nominees for membership on the Medicaid Peer Review Committee to the Executive Committee.

AMA Subcommittee on Aging . . . Congratulated David Eckstein, M.D. on his election by the AMA Council on Medical Service as a member of the Subcommittee on Aging of the Committee on Community Health Care.

AMA Automotive Safety Committee . . . Authorized the attendance (with expenses paid) of Irwin S. Smith, M.D., Chairman of MSNJ's Committee on Traffic Safety, at a meeting of the AMA Committee on Medical Aspects of Automotive Safety on May 6 in Washington, D.C.

College of Allied Health Professions . . . Agreed, upon recommendation of Karl T. Franzoni, M.D. (MSNJ's liaison representative to the New Jersey Health Careers Service) to approve in principle a proposal for the establishment of a college of allied health professions in New Jersey, as set forth in the position paper on this subject prepared by the New Jersey Health Careers Service.

. . . Requested that sufficient copies of the position paper, "A Position Paper Proposing the Establishment of a College of Allied Health Professions in New Jersey," be obtained for distribution to the members of the Board of Trustees.

Council on Legislation . . . Approved a recommendation of the Council on Legislation that the official position of MSNJ on S-422 (to permit a medical student to complete formal studies in three years) be changed to that of *APPROVED.*

(*Note*: As a consequence of a February 22, 1970 directive of the Board of Trustees to investigate S-422 further, it was learned that the New Jersey College of Medicine and Dentistry and the Rutgers Medical School, and the State Board of Medical Examiners, who had a large part in initiating the preparation and introduction of this legislation, were strongly in support of the measure.

. . . Approved the following recommended official position of MSNJ on bills of medical import:

(All measures thus marked (*) are identical to bills of last year—or preceding years—whose official positions were the same.)

*S-542—To provide that the need for a certificate under the act providing for certification of x-ray technicians shall not apply to a licensed dentist who operates only x-ray equipment for dental radiographs under the direct supervision of a licensed dentist and to provide for 9 examiners, in place of 10, on the x-ray technician board. *APPROVED*

S-559—To provide for the confidentiality of information and data secured by and in the possession of utilization review committees established by hospitals, extended care facilities, skilled nursing homes, or other health care service facilities. (Amended version of S-258 of this year which MSNJ actively supports . . . Our bill) *ACTIVE SUPPORT*

S-569—To establish a Children's Risk Register in the Department of Health for handicapped and high risk children to be used for their care, treatment, education and rehabilitation. *DISAPPROVED*, because it would be impractical of implementation because of its broad application and furthermore might lead to the stigmatization of a potentially handicapped child and might also cause a great deal of undue anxiety in some parents.

S-573—To provide for reporting of epileptiform seizures to the Director of Motor Vehicles by physicians and persons subject thereto. (Our bill) *ACTIVE SUPPORT*

S-574—To authorize counties and municipalities to make appropriations for the treatment and training of emotionally maladjusted or physically undernourished children between the ages of 5 and 12 years. *NO ACTION*

S-624—To provide for establishment of regional evaluation centers for mentally retarded, physically handicapped, emotionally disturbed, socially maladjusted and multiple-handicapped children. *DISAPPROVED*, because there is no evidence that present procedures and facilities are not adequate.

S-630—To establish a Department of Environmental Control in the Executive Branch of government. *NO ACTION*

*S-636—To provide that the State Sanitary Code shall not contain any regulation which requires or directs the mandatory fluoridation of any public potable water supply. *APPROVED*

S-666—To authorize the Governor to convene a Governor's Conference on Food, Nutrition and Health. *NO ACTION*

*S-671—To provide that grounds for refusal to grant, suspend, or revoke licenses to practice medicine, surgery or chiropractic shall include violations of any rule, regulation or code of ethics promulgated by the Board of Medical Examiners or where a practitioner is found guilty of unprofessional, dishonorable or unethical conduct. *DISAPPROVED*, because it is the proper function of the State Board of Medical Examiners to enforce the rules and laws governing the practice of medicine, and it is the province of the profession of medicine itself to enforce conformity with principles of ethics and standards of professional conduct.

S-674—To revise and repeal various statutory provisions to conform them to P.L. 1967, Chapter 254, which abolished county offices of coroners and county physicians. *APPROVED*

S-676—To grant immunity from liability, civil or criminal, to any physician, nurse, or hospital for any act or omission in the course of taking a breath sample at the request of a police officer. *APPROVED*

S-688—To provide for contents of certificate of birth established by the State registrar for adopted children and to assign to the adopted person the family name of the adopting parents. *APPROVED*

S-691—To provide for reimbursement of psychologist's services under any accident health or accident and health insurance. *DISAPPROVED*, as unnecessary . . . since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

S-692—To provide that service of a psychologist shall be deemed to be within the provisions of the Act concerning Medical Service Corporations. *DISAPPROVED*, as unnecesary . . . since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

S-700—To permit the Interstate Sanitation Commission under the Tri-State Compact to develop, after public hearing, and place in force classification of waters and effluent standards within the District. *APPROVED*

S-732—To provide that a violator of the motor vehicle laws shall be first advised that his refusal to submit to a breath test sample may subject him to revocation of his license for six months. *APPROVED*

S-745—To establish the Solid Waste Management Act and to create an Advisory Council on Solid Waste Management in the Department of Environmental Protection. *NO ACTION*

S-746—To authorize the Public Utility Commission to regulate the collection and disposal of solid waste under the "Solid Waste Utility Control Act." *NO ACTION*

A-273—To provide for a Second Injury Fund under the Workmen's Compensation Law; to require the State, county, municipality, district or public agency to make contributions thereto. *APPROVED*

A-506—To eliminate the requirement of a medical examiner's investigation in death cases occurring within 24 hours after admission to a hospital or institution and to eliminate the need for personal presence of the Medical Examiner, his deputy or assistant at the scene of the death requiring investigation. *APPROVED*

*A-518—To repeal the gross receipts excise tax on unincorporated businesses. *APPROVED*

A-589—To permit the superintendent of State Police to appoint physicians and other medical personnel to his staff as required. *APPROVED*

A-593—To require each migrant labor camp to pro-

vide for a water-carried sewage disposal system no later than November 1, 1970, in place of January 1. *APPROVED*

A-595—To increase penalties for violations of the narcotic drugs act. *APPROVED*

*A-600—To require ophthalmic dispensers to hold a high school diploma or equivalent in order to qualify for examination and certification. *APPROVED*

A-603—To provide for placing of persons on a permanent absentee voting list upon certification of a physician attesting to permanency of confinement due to illness or physical ability; to provide for mailing of such absentee ballots not less than eight days before each election by certified mail. *APPROVED*

A-620—To provide that the board of education shall require all school children to be immunized against poliomyelitis, measles and rubella disease and to permit such at public expense. *DISAPPROVED*, because we favor A-639 which is permissive legislation. A-620 would abrogate the discretionary powers of the boards of education.

A-621—To require all school bus seats to be equipped with seat safety belts of a type approved by the Director of Motor Vehicles. *NO ACTION*

A-639—To provide that the board of education may require immunization of school children against rubella. (See A-620) *APPROVED*

A-656—To provide for "occupational hearing loss" under the Workmen's Compensation Law. *APPROVED*

A-667—To require all law enforcement officers to determine if any person found in an unconscious state is wearing an identificatian tag indicating he is an epileptic or diabetic. *APPROVED*

A-694—To provide penalties for operation of a motor vehicle while under the influence of hallucinogenic drugs. *APPROVED*

A-695—To authorize the Director of Motor Vehicles to refuse to license or to revoke the license of a chronic alcoholic. *DISAPPROVED*, because there is no definition of "chronic alcoholic" nor are there standards or guidelines to determine who may or may not be a chronic alcoholic.

*A-706—To provide that nothing in the Workmen's Compensation Law shall be construed to render immune from liability (under the common law or otherwise) on account of injury or death, any person who, at the time of the injury or death, was in the employment of the same employer as the person injured or killed and who engaged in the practice of medicine, surgery, dentistry or chiropractic. *APPROVED*

A-726—To create an "Environmental Quality Council" in the office of the Governor. *NO ACTION*

A-730—To make the bringing of narcotic drugs or marihuana illegally into the State a misdemeanor. *APPROVED*

(*Note*: By action of the Board the position of "No Action," recommended by the Council, was changed to that of "Approved.")

A-744—To provide for the medical examination of school pupils who may be under the influence of narcotic, depressant, or stimulant drugs or any chemical or chemical compound. *APPROVED*

A-752—To create a Board of Hearing Aid Dispensers. *APPROVED*

A-762—To provide for legal abortions. *DISAPPROVED*, in that it exceeds the policy recommendations adopted by the 1968 House of Delegates of MSNJ in that it would permit an abortion on an unmarried woman, "provided that the pregnancy commenced while she was under the age of 16 years and is still unmarried at the time the abortion is performed."

A-763—To provide that the Board of Medical Examiners may refuse or revoke a midwifery license for termination of human pregnancy. (Companion measure to A-764.) *DISAPPROVED*, because the key phrase in the amendment used is much too broad. The birth of a child is itself a "termination of human pregnancy" and certainly that should not be considered grounds for revocation of a midwifery license.

A-764—To provide that the Board of Medical Examiners may refuse or revoke a physician's license for his failure to respect the limits set by State laws governing termination of pregnancy. (Companion measure to A-763.) *APPROVED*

A-776—To prohibit deposit of human body wastes on lands within the State and to regulate railroad toilets. *APPROVED*

A-794—To increase the penalty for pollution of potable waters to not more than $500 for the first violation and no more than $2,500 for subsequent violations, each day in place of week being a separate violation, and to permit any agency supplying potable water to institute action against polluters. *NO ACTION*

A-795—To prohibit the dumping of industrial waste into any of the waters of this State except under conditions approved by the Department of Conservation and Economic Development. *APPROVED*

A-802—To include under the immunity section of the Medical Practice Act any person who successfully completes a State Board of Medical Examiners approved course of training for certain ancillary medical services. (Our bill.) *ACTIVE SUPPORT*

A-828—To permit the Public Utilities Commission to require any public utility to furnish service which tends to conserve and preserve quality of environment and prevents pollution of water, land and air. *APPROVED*

A-834—To provide for eye examinations of every child enrolled in the kindergarten class. *DIS-*

APPROVED, because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or a physician licensed to practice medicine in the State of New Jersey would, in consequence, be an unjustifiable and expensive redundancy.

A-839—To authorize the Commissioner of Health to provide for residential care and treatment for drug addicts in existing non-State facilities. *NO ACTION*

A-840—To authorize the Department of Institutions and Agencies to provide for residential care and treatment of mental patients in existing non-State facilities. *APPROVED*

A-850—To provide that the Department of Education shall supply each school district with sufficient guidelines for teaching the effects of narcotics and depressant and stimulant drugs. *APPROVED*

*A-852—To provide that no dog or other animal caught or procured shall be made available for purposes of experimentation. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

A-854—To remove "Class X narcotic drugs" from exempt status under R.S. 24:18-7 concerning pharmacy prescriptions. *DISAPPROVED*, because although we recognize the danger in the abuse of these medications by youths the requirement of a physician's prescription for an adult purchaser creates an unwarranted expense with no appreciable equal benefit to the general public.

A-872—To provide that any person not a narcotic addict who sells, gives, administers or dispenses any hard drugs to a person over 16 years of age shall be guilty of a high misdemeanor and sentenced for life and upon a second conviction or if selling to a person under age 16 shall be guilty of a high misdemeanor and sentenced for life with no parole. *APPROVED*

(*Note*: By action of the Board the position of "No Action," recommended by the Council, was changed to that of "Approved.")

A-877—To require labeling of food where appropriate "This article of food was frozen and permitted to thaw." *NO ACTION*

*A-879—To require the licensing of persons who carry on the practice of medical technology and to create a Medical Technology Advisory Committee. *DISAPPROVED*, because there is currently in New Jersey and across the nation a serious ancillary personnel manpower shortage. This bill would serve to aggravate and intensify the dearth of qualified personnel and would thus have an untoward effect upon the delivery of quality health care.

A-880—To provide for an additional member to the State Board of Medical Examiners. *DISAPPROVED*, since the addition to the State Board of Medical Examiners of an individual expert in the licensing of medical technologists would be of no appreciable significance in view of our disapproval of A-879.

A-887—To reorganize the Department of Conservation and Economic Development as the Department of Environmental Protection and to establish therein the Divisions of Natural Resources, Fish, Game and Shell Fisheries, Water Policy and Supply and Parks, Forestry and Recreation. *APPROVED*

The following bills were noted and filed, as not being of intimate concern at this time.

S-582—To appropriate $50,000 to the Department of Education for teachers' workshop on drug abuse.

S-623—To provide that any fresh meat sold at retail shall be wrapped in an entirely transparent container.

S-665—To authorize the Newark Board of Education to use land heretofore allocated to the College of Medicine and Dentistry for the construction of a centralized secondary educational complex.

SCR-48—To establish a committee to study means of reorganizing governmental programs concerning environmental protection.

A-516—To provide that prepackaged meat shall be in containers which are colorless and transparent on all sides.

A-740—To authorize the Newark Board of Education to use land heretofore allocated to the College of Medicine and Dentistry for the construction of a centralized secondary educational complex.

ACR-52—To memorialize the Governor to reestablish the New Jersey State College of Medicine and Dentistry in the medical complex known as the Jersey City Medical Center.

ACR-57—To create a commission to study the problem of treatment of senility in hospitals and institutions established for treatment of the mentally ill.

ACR-66—To create a commission to inquire into the condition of the nursing homes and the personal care facilities for the aged.

Pre-adoptive Medical Examinations . . . Approved the following recommendation of the Council on Medical Services:

That the Board of Trustees record the Society's opinion with both the Catholic Welfare Bureau and the New Jersey Bureau of Children's Services that by reason of his training and experience any M.D. is capable of performing routine pre-adoptive medical examinations and can be relied upon to refer any questionable cases to a qualified pediatrician.

Relative Value Index . . . Approved the recommendation of the Council on Medical Serv-

ices that MSNJ adopt the Fourth Edition of the California Medical Association Relative Value Index.

(*Note*: The above is in response to a 1969 directive of the House of Delegates concerning an up-dated version of the relative value index, which had been referred to the Council on Medical Services.)

Denial of Medicare Benefits . . . Approved the following recommendation of the Council on Medical Services:

That MSNJ record itself as opposed to the retroactive denial of hospital and Extended Care Facility benefits under Medicare, and urge that all cut-off dates for payments be announced prior to the effective date of cessation of coverage.

Fee Inequities Under Medicare and Medicaid . . . Approved the following recommendation of the Council on Medical Services:

That the Society put itself on record with all third-party payers under health care programs as dissatisfied with the present circumstance which freezes the fees of all physicians as of a past date and leaves no channel open for the facile and equitable adjustment of those fees to cover increased costs of procedures of practice and general increased costs of living.

Finance and Budget Committee . . . Approved the report of the Committee on Finance and Budget, including recommendations to the 1970 House of Delegates. The entire report will be included in the Transactions Issue of *The Journal* (July) and is not preprinted here.

Conference on Medical Defense and Insurance . . . Accepted the report of the Joint Conference Committee (representatives of the Council on Legislation and the Committee on Medical Defense and Insurance) and directed that the following proposals included therein be circulated to the component societies for their information:

(*Note*: Realizing that the true value of any proposal in this area is difficult to determine, the Committee requested the Joseph A. Britton Agency to present the suggestions to representative defense attorneys employed by the insurance carrier for opinion. If any proposals are found to have merit, they will be submitted to the Board of Trustees for disposition.)

PROFESSIONAL LIABILITY PROPOSALS

1. Assess costs of $500 against the plaintiff's attorney (not against the plaintiff) for withdrawal of a law suit after the trial date has been set or if, in the opinion of the presiding judge, the attorney does not present adequate evidence at the trial. Costs shall be payable to the defendant or his insurance carrier.

2. Assess costs up to $500 against the defendant's attorney or insurance carrier (not against the defendant) if settlement is made after the trial date has been set. The presiding judge may waive the costs if settlement is made during the trial. Costs shall be payable to the court.

3. Provide immunity from suit, other than one alleging direct active negligence, for a physician responsible for ward of specialty services in a hospital or while serving on a committee of a hospital or medical society.

4. Provide privileged communication for a physician, serving on a medical review and/or advisory committee.

5. Provide immunity from suit for a physician, other than the attending physician, answering a call in a cardiac arrest case.

6. Provide that the Supreme Court Sub Panel be mandatory at the request of either the plaintiff or defendant.

7. Provide for an agreement between the patient and physician, entered into prior to or during treatment, to submit any claims for injury to the Supreme Court Sub Panel. (not necessary if #6 is accepted)

8. Provide for an agreement between the patient and physician, entered into prior to or during treatment, to arbitrate any claim for damages.

9. Permit advance payment to an injured party to be deducted from a future verdict or settlement and that it shall not be considered as an admission of liability nor can it be introduced as evidence in a trial.

10. Provide for a contingency fee schedule of reducing percentages at various levels of a settlement or verdict. Such fee could be inclusive of all expenses and costs for preparation and trial.

11. a) Provide that the Statute of Limitation begins to run from the date of the alleged negligent act.

b) Provide that in situations where the plaintiff is a minor, his parents suing either in his name or their own must bring suit within two years of the commission of the negligent act.

Joint Conference of County Society Presidents . . . Met with representatives of 14 component societies for discussion of the following items: (a) arbitration clause in hospital consent form for treatment (currently under consideration—#8 of above proposals); (b) proposed Medicare Part C (prepaid insurance under group practice); (c) liability protection for physicians participating in the State's rubella vaccination program (State Department of Health provides such insurance); (d) pharmacy regulation #2, 45:14-14 of the Revised Statutes (no prescription may

be filled in an institution or hospital unless it is in the original handwriting of the licensed physician—Board of Pharmacy reports that the regulation is being held in abeyance for reconsideration); (e) the desirability of a welfare fund for physicians; (f) a full time public relations counsel (referred by the Board to the Council on Public Relations), and (g) the tone of communications to patient indicating that where charges exceed payments agreed to by Medicare the doctor is guilty of overcharging (already under discussion with the fiscal intermediary).

Board of Medical Examiners . . . Directed that the names of the following nominees for appointment to the Board of Medical Examiners be submitted to the Governor (Dr. Anthony J. Balsamo's term expired on April 24, 1970):

Anthony J. Balsamo, M.D., Jersey City
Charles Cunningham, M.D., Vineland
Richard P. Keating, M.D., Ridgewood
Raymond A. McCormack, Jr., M.D., Trenton
John J. McGuire, M.D., Newark
Isaac N. Patterson, M.D., Westville
Frederick C. Steller, M.D., Spring Lake

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during April 1970.

	1970 April	1969 April
Aseptic meningitis	11	16
Primary encephalitis	7	2
Post-infectious encephalitis		0
Hepatitis: Total	324	181
Infectious	259	153
Serum	65	27
Malaria: Total	6	4
Military	5	2
Civilian	1	2
Meningococcal meningitis	16	12
Mumps	480	158
German measles	139	109
Measles	306	114
Salmonella	51	17
Shigella	14	14

Measles

Measles (rubeola) in New Jersey increased markedly during the first quarter of 1970. Between Jan. 1 and March 31, 1970, more than 800 cases of measles were verified by the New Jersey State Department of Health. This represents practically a three-fold increase over the 295 cases documented during the same period in 1969. A disturbing feature of this trend is that three cases of measles encephalitis have been reported. This stands in bold contrast to the virtual absence of measles encephalitis throughout 1969. The three cases of encephalitis further suggest that we are witnessing a failure of reporting since it has been estimated that encephalitis complicates measles approximately once in every thousand cases. Additionally, there have been six reports of pneumonia complicating measles. Thirteen children have been hospitalized for complications of measles.

The counties that have had the heaviest measles morbidity are Sussex, Ocean, and Cumberland, with Gloucester, Burlington, and Monmouth counties also reporting large numbers of cases.

The New Jersey State Department of Health maintains an active measles vaccination program, and is prepared to assist local and county health departments in conducting immunization campaigns. Vaccine, supplies, and technicians utilizing hypo-spray jet injector guns are provided at no cost to the municipality or individual. We have found that the most effective vaccination programs are those which are school-based. The Acute Communicable Disease Control and Vaccination Assistance Programs encourage municipalities to conduct programs, particularly in areas where measles morbidity exists.

Salmonellosis in a Pediatric Ward

An outbreak due to *Salmonella typhimurium* was investigated in the pediatric ward of a hospital in southern New Jersey. The pathogen was isolated from ten patients between two months and five years of age between March 22 and April 20. Initial investigation

was conducted on April 10 when there were only four confirmed cases, but no common source could be established at that time. All four patients (two of whom were siblings) were hospitalized with gastroenteritis and it was concluded that these were sporadic, unrelated incidents. Since that investigation, however, children who had been hospitalized for other reasons developed diarrhea and fever and blood and stool cultures revealed no less than six additional cases which were positive for *S. typhimurium*. Spread of the pathogen is believed to have been person-to-person. Recommendations to control the outbreak included the following:

1. Isolation of all pediatric patients known to be infected or having gastroenteric symptoms.

2. Improved personal hygiene practices of hospital personnel with particular attention to hand washing procedures.

3. Early hospital discharge of infected children.

4. Separate hospital personnel for the care of children in isolation.

5. Special tagging and handling of laundry and fomites from the isolation ward.

Other pathogenic organisms were also isolated during the survey, including *Shigella sonnei* and *enteropathogenic E. coli*. These infections are believed to have been community-acquired and were not spread during the course of the outbreak.

You And The Radiologic Survey

The Public Health Service has initiated a study to obtain information on population exposure to diagnostic and therapeutic radiation. It is being conducted by the Bureau of Radiologic Health and the National Center for Health Statistics. The study was planned with the advice of the American College of Radiology.

The study will be conducted in three phases:

1. A household interview survey to obtain the x-ray visit experience of a representative sample of the U.S. population. This will cover about 20,000 households and 65,000 persons.

2. A follow-up questionnaire to obtain examination data from x-ray facilities identified in the household survey. Some 5,000 facilities will be asked to supply these details. Authorization to request the information will be obtained in advance from household respondents.

3. An x-ray equipment survey will provide physical measurements in a selected sample of x-ray facilities. This is being conducted by specially trained State and Federal radiologic health personnel.

Based on data obtained during the household and facility surveys, a descriptive analysis of the population's x-ray experience in 1970 will be prepared. The information will include estimates of numbers and rates for: (1) persons x-rayed; (2) x-ray visits; and (3) x-ray examinations and exposures.

Estimates of gonadal and genetically significant dose will be derived from the study findings by applying mathematical models developed at the Johns Hopkins and Emory Universities. The data will be projected into dose estimates for other selected body organs through the use of related research results.

The cooperation of each practitioner contacted in the follow-up phase is essential to meet the study objectives. All information pertaining to individual patients, practitioners, and facilities will be treated confidentially. Only statistical summaries will be made available for publication.

Additional information about plans for the survey may be obtained from the Bureau of Radiologic Health, 1901 Chapman Avenue, Rockville, Maryland 20852.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

FAMILY PRACTICE—David J. Bush, M.D., Hennepin County General Hospital, Minneapolis, Minnesota 55415. University of Iowa 1969. Group. July 1970.

GENERAL—Kuchak Jalali, M.D., 41-31 51st Street, Woodside, New York 11377. Teheran 1959. Available June 1970.

INTERNAL MEDICINE—Panagis Kokolis, M.D., 1602-D South 30th Street, Philadelphia, Pennsylvania. University of Athens (Greece) 1957. Board eligible. Group, partnership, or solo. Available.

Allan M. Sulzer, M.D., 1148 Plainfield Road, Cleveland, Ohio 44121. University of Pittsburgh 1964. Board eligible. Partnership. Available December 1970.

Luis A. Amill, M.D., 10 East 78th Street, New York 10021. Columbia 1921. Part-time only, hospital, institution, or college. Available August 1970.

OTOLARYNGOLOGY—Phil Brunner, M.D., 5 Clipper Road, Palos Verdes Peninsula, California 90274. NYU (Downstate) 1965. Board eligible. Group. Available August 1970.

James S. Butler, M.D., Bassett Army Hospital (Fairbanks, Alaska), APO Seattle, Washington 98731. George Washington 1963. Board certified. Partnership, group, or solo. Available February 1971.

PATHOLOGY—Frank P. Urso, M.D., 100 Beatty Road, Media, Pennsylvania 19063. University of Miami 1962. Board eligible. Partnership, solo, institution. Available August 1970.

Walter C. Beck, M.D., c/o Drew, 2314 Park Avenue, Richmond, Virginia 23220. George Washington 1947. Board certified. Hospital (solo or associate) or private laboratory (associate or partnership. Available June 1970.

PEDIATRICS—Thavorn Kunakasem, M.D., 208 Highland Road, Cape May Court House, New Jersey 08210. University of Medical Science, Thailand 1957. Board certified. Group or partnership. Available.

Dudley L. King, M.D., 11852 Big Tree Road, East Aurora, New York 14052. NYU at Buffalo 1954. Board certified. Associate or group. Available July 1970.

Howard Singer, M.D., 265 Explorer Street, K.I. Sawyer AFB, Michigan 49843. University of Pittsburgh 1965. Board eligible. Group or partnership. Available October 1970.

Parviz Pishva-Zadeh, M.D., c/o Todaro, 5601 14th Avenue, Apt. 4F, Brooklyn, New York 11219. Tehran 1959. Board certified. Solo or partnership. Available July 1970.

RADIOLOGY—Santos F. Delgado, M.D., 2201 Dublin Road, Pulaski, Virginia 24301. Santiago (Spain) 1953. Board certified. Group, partnership, or associate. Available spring 1970.

SURGERY—Edward Mussad, M.D., 115-D Fort Lee Road, Leonia 07605. Cairo University, 1957. Board certified. Group, partnership, or solo (commuting distance New York City). Available.

UROLOGY—Arturo Canto, M.D., 89-50 56th Avenue, Elmhurst, New York 11373. University of Philippines, 1962. Board eligible. Group or partnership. Available.

R. Soundararajan, M.D., 6439 North Broad Street, Philadelphia 19126. Madras University (India) 1959. Partnership or group. Available August 1970.

School Tuberculin Testing

The Tuberculosis Council of New Jersey has updated the *School Tuberculin Testing Guide*, originally published in 1964. This new version of the *Guide* supplements the revised regulations for tuberculosis screening in the schools, adopted by our State Department of Education in May 1969.

The *Guide* is designed to provide the school nurse and the school physician with procedures that may be used in a school tuberculin testing program. It should also be of interest to others in fields of education and health. The prevention of tuberculosis, through the use of isoniazid prophylactically for tuberculin reactors is now discussed. Also newly added are nursing guidelines for preventive therapy and for the follow-up of tuberculin reactors. Other sections discuss procedures for the administration and reading of tuberculin tests and the various forms required for notification, records, and reporting.

The Tuberculosis Council of New Jersey is composed of representatives from voluntary and official agencies—co-chaired by the Commissioner of Health, Director of TB-RD, and Chief Medical Consultant of NJI&A.

Requests for the *Guide* should be sent to the State Department of Health, Division of Preventable Diseases, P.O. Box 1540, Trenton.

AMA Convention

Chicago, the city with a knack for news, will host the 119th Annual Convention of the American Medical Association, June 21 to 25.

The hub of the Scientific Program (which was published in full in the May 4 *JAMA*) will be the Chicago International Amphitheatre. Site of many of American's most memorable political conventions, this is fully air conditioned and its expanse permits presenting the entire AMA scientific program on one floor under one roof. On view will be 450 scientific and industrial exhibits. All 23 sections of the Scientific Assembly will be represented. Four general scientific meetings will be addressed to: Coma and the Diagnosis of Death, Conception Control and Abortion. The Role of Allied Health Professions in the Delivery of Health Care, and Family Life and the Physician.

The Section of Special Topics will cover suicide, adverse reactions, drug interactions, neurologic surgery, occupational diseases, plastic and maxillofacial surgery, and nuclear medicine. The Multidiscipline Research Forum will present 50 papers prepared by prominent scientists.

Among the citations to be conferred are the Hektoen and Billings Awards, the Joseph Goldberger Award in Clinical Nutrition, the Distinguished Service Award, the Scientific Achievement Award, and the Citation of a Layman for Distinguished Service.

Service provided by the AMA will be free bus transportation between major hotels and the Amphitheatre each day. Another transportation convenience will be provided on Wednesday and Thursday for departing registrants: bus service at 30 minute intervals from the Amphitheatre to O'Hare International Airport at $2 per person. On Wednesday, the buses will operate between 2:30 and 5 p.m., and from 2 to 4:30 p.m. on Thursday.

You can be well-briefed on the meeting highlights by viewing the special closed circuit TV programs transmitted to downtown hotel rooms. Telecasts will present major news of the scientific program, actions of the House of Delegates, special events, and topics of interest to women. The telecasts will be presented in color.

A special convention *Daily Bulletin* will be distributed in hotels throughout the week.

Receptions, luncheons, and dinners for alumni organizations and specialty groups will abound. These "timetables" were also carried in JAMA, May 4.

Among the most colorful programs will be the opening of the AMA House of Delegates at 2 p.m. on Sunday, and the Inaugural Ceremony installing Walter C. Bornemeier, M.D., as the Association's 124th President at 5 p.m. on Wednesday, followed by the President's reception at 6 p.m. in the Palmer House.

The House of Delegates will meet each day in the Palmer House, except on Monday when the reference committees discuss resolutions introduced by the state delegations.

A special program for youngsters and teenagers of medical families promises a memorable and educational visit. Exciting tours, departing from and returning to the Drake Hotel, include swim and sightseeing parties, a theater-dinner night at a country playhouse, tours to museums, zoos, newspaper plants, the police academy, the Board of Trade, the University of Chicago campus, and boat cruises on Chicago's magnificent lakefront.

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ANNOUNCEMENTS

EENT Seminar

The New Jersey Academy of Ophthalmology and Otolaryngology will present a program at the Seaview Inn, Absecon on July 1, 2, and 3. The agenda includes a paper on orbital and facial injuries and another on laryngeal surgery. Also scheduled is a combined section on osteoplastic mastoidectomy technic in tympanoplasty and dacryocystorhinostomy technic. Physicians who play golf can register for the golf tournament on July 1 (the scientific program is held on July 2 and 3). For more details, write to Herve M. Byron, M.D., 220 Engle Street, Englewood 07631.

Courses In Ophthalmology

The Post-Graduate Institute of the New York Eye and Ear Infirmary announces graduate courses for specialists in ophthalmology, September 9 through 20, 1970. These include ocular prostheses, biomicroscopy, cataract surgery, perimetry, contact lenses, corneal surgery, ultrasonography, fluorescein angiography, glaucoma, gonioscopy, lacrimal sac surgery, microsurgery, motor anomalies, neuro-ophthalmology, ocular geriatrics, orbital anatomy, plastic eye surgery, applanation tonometry, radioisotopes, reading disability, surgery of the orbit, and uveitis.

At the conclusion of the regular series, a special six-day review in basic sciences in ophthalmology will be given, December 7 through 12.

For a catalogue and further information, please write to the Post-Graduate Institute, New York Eye and Ear Infirmary, 310 East 14th Street, New York 10003.

Surgeons Meet in October

The world's largest surgical conclave is scheduled for Chicago during the week of October 12. A feature will be the "Forum on Fundamental Surgical Problems." Also on deck are 18 accredited postgraduate courses, seminars with leading surgical professors, panel discussions on all the surgical specialties, an unusual "What's New in Surgery?" colloquium. and a packed program of practical papers. For details, write to the American College of Surgeons, 55 East Erie Street, Chicago 60611.

Graduate Course in Laryngology and Bronchoesophagology

The University of Illinois will conduct a graduate course in laryngology and bronchoesophagology from November 9 through 20, 1970. This course, limited to fifteen physicians, will be held largely at the Eye and Ear Infirmary of the University of Illinois Hospital, Chicago, and will include visits to other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures and several motion pictures. If interested, write to the Department of Otolaryngology, College of Medicine, University of Illinois, P.O. Box 6998, Chicago, Illinois 60680.

Cancer Of The Colon And Rectum

January 7, 8, and 9, 1971 are the dates for the next conference on cancer of the colon and rectum. This will be held at the Coronado Hotel in San Diego, California. Scheduled is a wide-angle, multi-disciplinary presentation of the rectal and colon cancer problem in the United States by leading authorities in epidemiology, etiology, detection, diagnosis, and treatment. Programs and approaches to control this disease will be discussed. For further information, write to Roald N. Grant, M.D., at the American Cancer Society, 219 East 42nd Street, New York 10017. All members of the medical and related professions and research investigators are invited to attend.

LETTERS TO THE JOURNAL

The Clergy Service Replies

April 10, 1970

Dear Sir:

I read with great interest the letter of Dr. Werner Steinberg to *The Journal* in the March 1970 issue. He made certain points about which we would be in disagreement. He says that abortion "has very little to do with theology." The truth is quite to the contrary. If abortion were not a profoundly religious question, I doubt that it would be such an issue today. Would Dr. Steinberg deny, for instance, that the division of opinion on abortion in New Jersey is not religiously based? Similarly, it seems to me, the whole question of the beginning of the kind of life that we call "human"—whether it is at the time of conception, quickening viability, or delivery —is as much a religious question as a medical one.

Nevertheless, much more unites Dr. Steinberg and the Clergy Consultation Service than divides us.

As an organization, we have repeatedly testified at Trenton for the repeal of existing laws; that the decision to terminate a pregnancy belongs only to the woman in consultation with her doctor; that the State has no right, morally or constitutionally, to infringe either on the religious beliefs of its women or on the rights of its certified doctors to practice medicine in the best interests of their patients.

The New Jersey Clergy Consultation Service on Abortion has counseled with over 2,000 women with problem pregnancies. We are currently counseling 75 women a week. We are privileged to merit the confidence of many, many obstetricians and gynecologists in New Jersey. But we see our organization only as a temporary one—seeing to it that women who have already decided to terminate their pregnancies avoid the quacks, the midwives, and the profit-seekers, and receive competent medical help from qualified obstetricians in states and countries where the laws are more humane than they are in New Jersey.

We invite you to join with us in our hopes for a state with enlightened, just, and humane laws that are of service to its women. Perhaps the combined influence of the doctors and the clergy of New Jersey could be a powerful instrument for repeal.

(signed) John G. Wightman
(Director, New Jersey Clergy
Consultation Service on Abortion)

Editor's Note: Dr. Steinberg's point was that the Service would seem to be violating the law, and he was concerned, even with good motives, whether this was a proper activity for a clerical organization.

Medical Education in New Jersey: A New Approach

April 24, 1970

Dear Doctor:

In the November 1964 issue of this *Journal*, I published a letter under the title, "Medical Education in New Jersey." It discussed the medical school problem with a suggested seven point plan to meet the 1964 medical education needs. *The Journal's* introduction commented: "The day after this letter was received, announcement was made that the legislature favored a plan which in part was not unlike Dr. Brodkin's recommendations." A recent issue of the Rutgers Medical School *Newsletter* now prompts me to offer a more up-to-date plan to provide the largest number of medical graduates at acceptable cost.

In view of the State's huge expenditures, the Governor understandably expressed deep concern over the 150 million dollars in construction costs required for training facilities compared with the insufficient number of physicians that these facilities will produce. Even this does not take into account the mounting costs of operation and the rapid

obsolescence of the highly sophisticated educational and diagnostic equipment which will be constantly required.

Unfortunately, there never was a single coordinated planning group in New Jersey medical education. One group established the New Jersey College of Medicine and Dentistry with classes of 80 students to be subsequently increased to 115. Another group established a two-year medical school in New Brunswick with classes of 16. This was to be increased to 80 by 1972. The plans also call for a 428-bed teaching hospital, which is far more costly in operation than a comparable modern general hospital would be. Rutgers Medical School seems to have embarked on a plan to produce medical scientists, and to engage in extensive research. This is commendable as an ultimate goal, but it appears to ignore the critical deficit of practicing physicians. Our problem is how to produce the largest number of practioners with minimum disturbance to present establishments at an acceptable cost. In approaching this, the following is suggested:

1. Rutgers Medical School prepare itself as a two-year medical college for 100 students in each class. The initial two years require mostly laboratories and lecture facilities. The minimal clinical facilities needed are adequately provided by existing neighboring hospitals. This would remove, for the time being, the necessity for the 428-bed teaching hospital.

2. At the completion of their second year in New Brunswick, the 100 students would be transferred to Newark. They would join the 115 student classes already enrolled in the Newark facility. The second half of the medical curriculum is almost exclusively clinical, with teaching carried on in the hospitals. The 215 student classes would be divided into sections allocated among the numerous large hospitals of the metropolitan area which have agreed to participate. A small teaching hospital of 200-beds, in addition to Martland Hospital, would be more than adequate for the purpose.

3. This would require unified coordination, and could be more readily and efficiently accomplished if the New Jersey College of Medicine and Dentistry were merged with the Rutgers Medical School under a single administration, probably the State University (Rutgers) School of Medical Sciences.

4. At the present time there are hundreds of New Jersey medical students studying in foreign countries. Though they may receive good training, road-blocks are put in the way of their taking State Board examinations. This obstacle is unfair and unnecessary. Not only that, but it represents a wasteful loss of potential practitioners. A simple policy change would correct this.

5. In view of the present physician shortage and the fact that several medical schools have reduced their course to three years, the State's medical educators should at least consider this approach during the present medical crisis. Elimination of summer vacations would provide curriculum acceleration with no degradation in the quality of New Jersey's medical educational program.

(signed) Henry A. Brodkin, M.D.

OBITUARIES

Dr. Louis W. Abbamonte

Just as he was about to become President-Elect of the Essex County Medical Society, Louis W. Abbamonte, M.D., died suddenly on April 30, 1970. Dr. Abbamonte was only 62 years old at the time of his death. He earned his M.D. at Georgetown University in 1932. During World War II he was a Lieutenant Colonel in the Medical Department of the Army of the United States. Dr. Abbamonte was a general practitioner with special skill in surgery and was on the surgical service at the Montclair Community Hospital. He was active in the New Jersey Chapter of the American Academy of General Practice.

Dr. Abraham Berkow

Abraham Berkow, M.D., one of our State's best-known pediatric allergists, died on April 20, 1970. Dr. Berkow was born in 1909 and received his M.D. at the Medical School of the University of Glasgow (Scotland) in 1935. He did graduate work in pediatrics, won a board diploma in that specialty, and became interested in allergies among children. He was chief of the allergy clinic at the Hackensack Hospital, and Associate Director of the Pediatric Service there. He was elected to Fellowship in the American Academy of Pediatrics. Dr. Berkow was a member of the Bergen County Medical Society.

Dr. Taeke Bosch

Taeke Bosch, M.D., one of the senior psychiatrists of New Jersey, died on March 8, 1970 at the age of 85. Dr. Bosch was one of the charter members of the New Jersey Neuropsychiatric Association. Although he lived and practiced in Hohokus, in Bergen County, he was also identified with the Post Graduate Hospital in New York, and had staff affiliations at the Hackensack Hospital and at the Valley Hospital in Ridgewood. Dr. Bosch was born in The Netherlands in 1885 and came to the United States as a child. He was graduated from the University of Iowa Medical School in 1915.

Dr. J. Lawrence Evans

One of New Jersey's longest and most useful medical careers ended on April 14, 1970 with the death that day of J. Lawrence Evans, Sr., M.D. He was born in 1879 during the Presidency of Rutherford B. Hayes. In 1896, at the age of 17, he took over his sister's country school, one of the youngest school teachers in Pennsylvania. In his spare time, he studied the new science of accountancy and then taught that subject at Philadelphia's Drexel Institute. But in 1906, at the age of 27 he decided that his vocation was medicine, not business, and he entered the Jefferson Medical College that year, getting his M.D. in 1910. After two years of general practice, he became affiliated with the group that organized the North Hudson Hospital in Weehawken, and except for his military service, devoted practically all the rest of his active professional life to that hospital. He was active, too, in the affairs of the Hudson County Medical Society, serving in nearly all of its offices including that of president.

During World War I he was first a battalion surgeon, then a medical inspector. He served in France and Belgium. In 1961 he retired as administrator of the North Hudson Hospital and the Hudson *Dispatch* editorially commented then: "With his retirement, the entire North Hudson community will suffer a void which will never again be filled with the degree of success, understanding, and service which were shown by Dr. Evans."

This *Journal* is especially saddened by this loss because, for many years, Doctor Evans was a helpful and respected member of our Publication Committee.

Dr. Manuel Hernandez

On February 24, 1970 Dr. Manuel Hernandez of Jersey City died at the age of 73. A well-known general practitioner, Dr. Hernandez served as Hudson County physician for several years. He was affiliated with the Fairmount Hospital in Jersey City. Dr. Hernandez received his M.D. at the Medical School of the University of Pennsylvania in 1921.

Dr. Frank F. Jani

Frank F. Jani, M.D., former Director of Surgery at St. Mary's Hospital in Passaic, died on April 16, 1970, at the age of 67. He was an alumnus of the class of 1927 at the Medical School of Georgetown University, and he was a Fellow of the American College of Surgeons. Dr. Jani was active in civic affairs in Fort Lee, to which community he moved after spending most of his professional life in Passaic.

Dr. Emil M. Kaney

On April 4, 1970, at the untimely age of 64, Emil M. Kaney, M.D., died at his home in Maplewood. Dr. Kaney was a 1938 alumnus of the University of Vienna, and did gradnate

work in psychiatry at the famous psychiatric clinics in that city. He was affiliated here with the St. Barnabas Medical Center, and with the Columbus Hospital. Dr. Kaney was active in committee work for the Academy of Medicine and was a member of our Essex County Medical Society.

Dr. Bela Markovits

Bela Markovits, M.D., a member of the World Medical Association, died in Trenton on March 27, 1970. Dr. Markovits was born in 1904 and was a 1931 graduate of the Medical School of the University of Budapest. He came to New Jersey shortly after World War II and was licensed in our state in 1954. He was a general practitioner and was active in the American Academy of General Practice. He was particularly interested in geriatrics and was on the staff of the St. Francis Hospital in Trenton.

Dr. William G. Mears

Word has just been received from Florida of the death, on January 18, 1970, of William G. Mears, M.D., who died at the age of 71. Dr. Mears was a well-known orthopedic surgeon who practiced in both Newark and Jersey City before he retired in 1964. He was the attending orthopedic surgeon for some years at the St. Francis Hospital in Jersey City. He received his M.D. from Columbia University College of Physicians and Surgeons in 1925.

Dr. Milton Neibrief

A busy and effective surgical career was cut short on April 5, 1970 with the death that day of Milton N. Neibrief, M.D. Dr. Neibrief was only 58 at the time of his passing. He was a member of our State Society of Surgeons, a board diplomate in surgery, and attending surgeon at the Kessler Institute in West Orange. He was also an attending surgeon at the Hospital for Crippled Children and was on the surgical staffs of the Newark Beth Israel Medical Center and the St. Barnabas Medical Center. Dr. Neibrief was a 1939 graduate of the medical school of the University of Nebraska.

Dr. Arthur G. Pilch

One of Essex County's best-known surgeons died in Florida on April 15, 1970. He was Arthur G. Pilch, M.D., who was, for many years, senior surgeon at the East Orange General Hospital and on the surgical staff of the Presbyterian Hospital in Newark. Born in 1892, he was a member of the class of 1916 at the New York Medical College, and he was a Fellow of the American College of Surgeons. He was active in committee work for the New Jersey Academy of Medicine. Dr. Pilch retired in 1961 and established homes in Maine and Florida.

Dr. Roberto Principato

One of New Jersey's senior practitioners, Roberto Principato, M.D., died on April 5, 1970 at the age of 80. He was a graduate of the Medical School of the University of Naples in the class of 1914, and he came to the United States the following year. Dr. Principato served in the Medical Department of the Army during World War I, with the rank of Captain. On his return he practiced in Camden and served the people of southern New Jersey for a half century. In 1964 he was a recipient of the MSNJ Golden Merit Award.

Dr. Robert I. Siegel

Word has just been received of the death last September 14th of Robert I. Siegel, M.D., who died at the tragically young age of 50. A Bellevue graduate, class of 1944, he entered the army promptly after completion of his internship and served as a captain in the medical corps, remaining in service until the end of 1947. He then established his office in Westfield and became a Fellow of the American College of Surgeons. He was on the staff of the Overlook Hospital in Summit, rising through the ranks and eventually becoming an attending surgeon there. He was an associate in surgery at St. Barnabas Medical Center in Livingston, and a consultant in surgery at the Children's Hospital in Westfield. Dr. Siegel was active in our Union County Medical Society.



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Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
Vaginal inserts . . 500 mg.

*References available on request.

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Owner Breaks Arm When Yacht Runs Aground

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] large rock tially capsized. The fire depart had to rescue Waters by small Damage to the yacht is estima

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. Contraindications: Hypersensitivity to any of the components. Precautions: As with all phenacetin-containing products excessive or prolonged use should be avoided. Side effects: Side effects are uncommon, although nausea, constipation and drowsiness may occur. Dosage: Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



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500 mg. capsules maintain optimal levels around-the-clock on b.i.d. dosage

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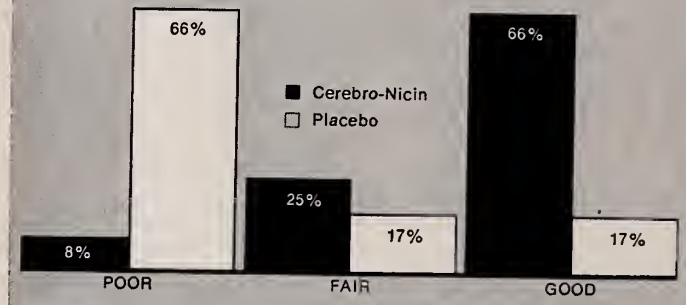
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
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Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8 oz. bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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The treatment of

impotence

NEW CLINICAL STUDY

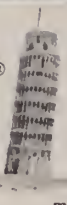
in the American male is complex. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study)
T. Jekobovits
Fertility and Sterility, Jenuery 1970
Official Journal of the American Fertility Society



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Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Ketosteroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

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Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (1½ gr.) ... 30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
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EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (½ gr.) .. 15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL ..... 5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications – Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. Montesano, P., and Evangelista, J. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Bobbie, M. F. Treatment of impotency with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Triett, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Heilman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Collins, S. W. Effects of L-thyroxine and isothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

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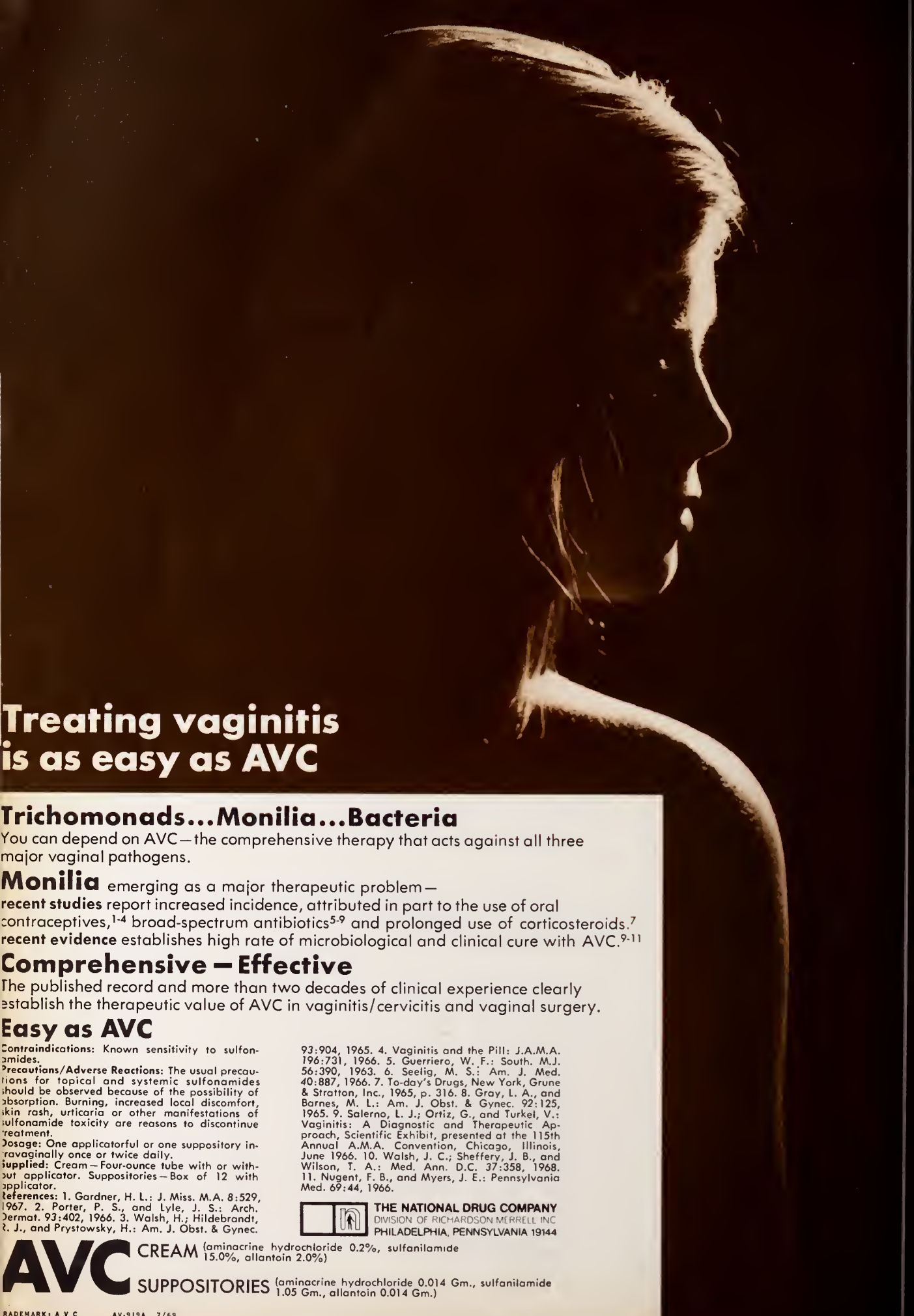
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References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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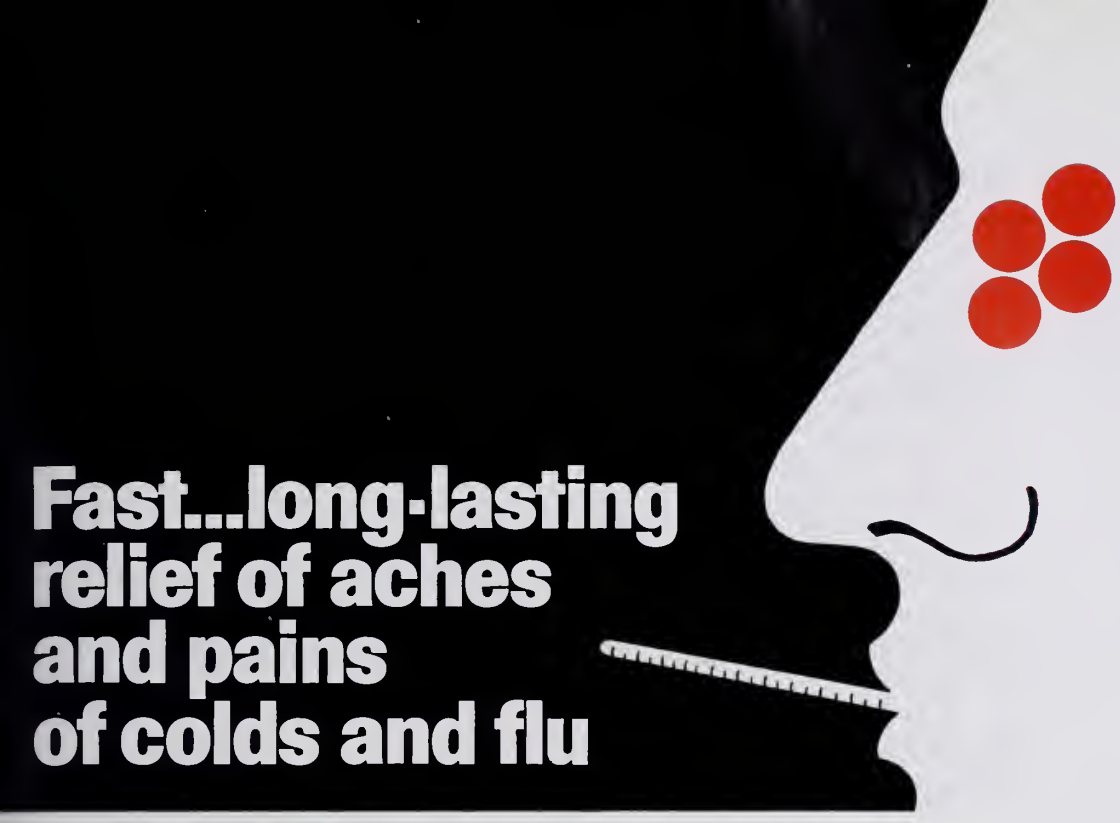
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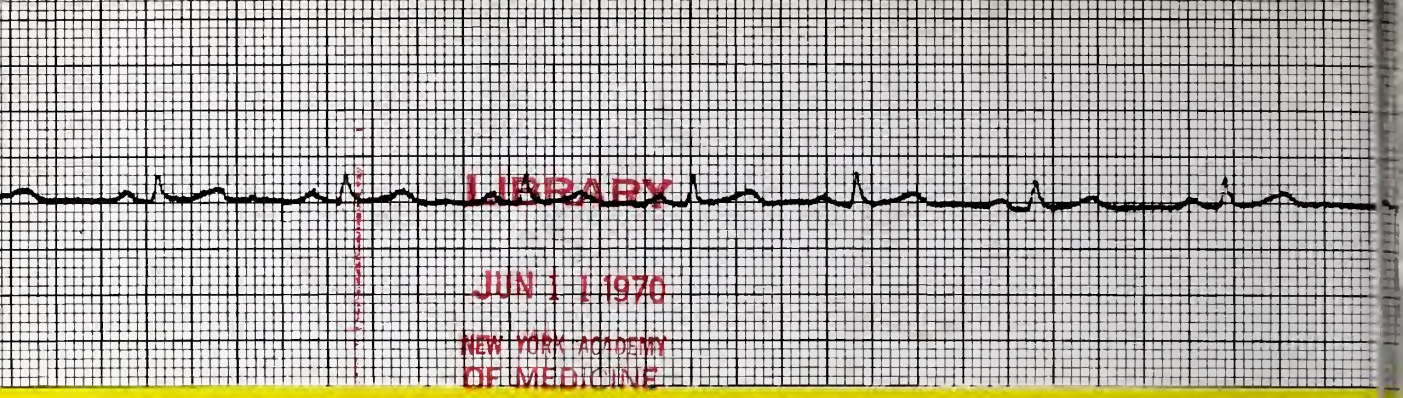
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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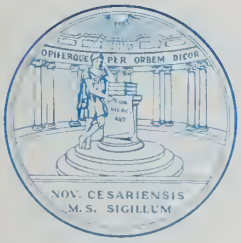
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the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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JULY 1970
VOL. 67, NO. 7

204th ANNUAL MEETING
TRANSACTIONS ISSUE

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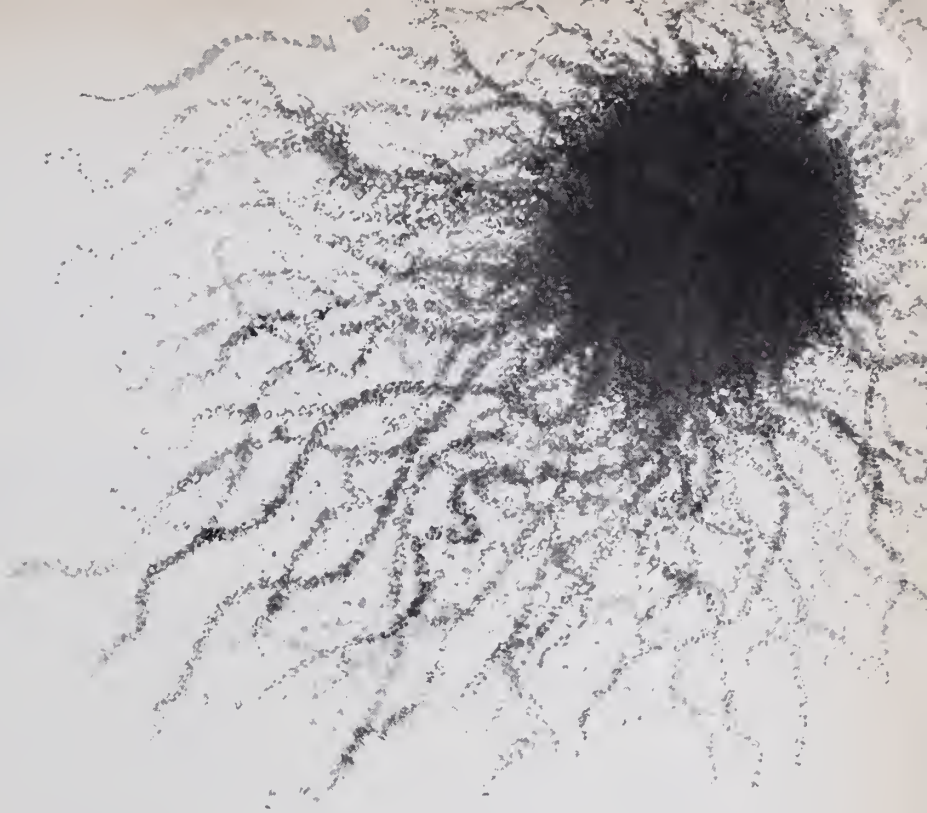
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For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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See Clinical Considerations section on last page...

Mounting acceptance in the hospital...

Proven clinical effectiveness



Respiratory Infections

Outstanding results in serious gram-negative respiratory infections[1,2]

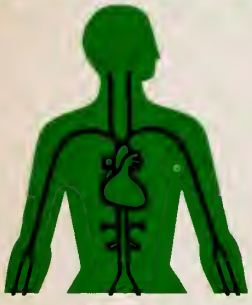
GARAMYCIN Injectable may prove successful where other antibiotics have failed.



Urinary Tract Infections

Strikingly effective in selected urinary tract infections[3]

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving[4-6]

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.[6]



Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

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Over 95% gram-negative pathogens sensitive.*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.
In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains Number of strains tested Antibiotics*							
	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	99.5% 962	84.7% 992	86.2% 995	76.1% 67	32.7% 1,020	96.3% 640	82.9% 1,028	77.1% 1,026
Aerobacter aerogenes	95.9% 2,739	86.1% 2,818	53.5% 2,985	58.8% 1,514	22.7% 3,066	88.6% 2,603	85.8% 3,071	67.8% 2,981
Klebsiella aerobacter group	98.8% 566	83.9% 547	66.1% 522	60.5% 276	28.0% 553	89.5% 560	86.2% 587	62.8% 433
Klebsiella, all others	92.7% 2,944	83.3% 3,186	77.4% 2,976	67.5% 627	13.5% 2,883	95.0% 2,105	81.6% 3,212	70.6% 3,063
Pseudomonas aeruginosa	91.6% 4,528	29.8% 4,460	6.6% 4,418	6.6% 1,279	6.0% 4,360	91.3% 3,852	26.9% 4,608	26.4% 4,404
Proteus, indole-positive	91.8% 1,031	85.8% 1,062	39.9% 981	54.1% 364	40.2% 1,042	10.3% 758	76.1% 1,096	42.1% 1,051
Proteus mirabilis, indole-negative	94.9% 3,272	90.1% 3,378	83.1% 3,290	77.5% 975	78.0% 3,274	8.8% 2,634	85.9% 3,469	26.8% 3,278
Proteus, unspecified	96.2% 1,335	85.8% 1,371	71.7% 1,434	70.0% 647	64.7% 1,435	11.2% 1,233	76.0% 1,421	22.4% 1,298
Escherichia coli and all other *Escherichias*	96.4% 12,557	91.4% 12,818	87.8% 12,686	88.8% 4,251	74.6% 12,899	95.4% 10,623	94.1% 13,086	70.0% 12,559
Paracolobactrum, all	93.4% 303	88.9% 325	62.0% 305	74.2% 62	43.8% 340	80.9% 215	87.1% 350	72.6% 340
Coliform bacteria	99.0% 593	91.2% 649	81.5% 637	66.7% 21	52.7% 624	95.6% 607	91.6% 678	76.1% 637
Totals	95.1% 30,830	80.5% 31,606	65.3% 31,229	68.1% 10,083	50.3% 31,496	75.8% 25,829	79.7% 32,606	56.5% 31,070
Gram-positive (Included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus,* coagulase-positive	97.4% 1,548	88.8% 1,458	97.7% 2,050	98.7% 636	61.1% 1,559	20.4% 628	94.4% 2,123	83.7% 1,966
Staph—*S. aureus,* unspecified	99.3% 993	92.8% 902	98.1% 1,289	95.3% 213	45.8% 1,153	29.3% 116	96.4% 1,427	82.3% 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).[5]
Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.
Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.
Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.
It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable Garamycin®
brand of
gentamicin sulfate injection

See Clinical Considerations section on last page...

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brand of gentamicin sulfate injection

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	**Less Severe** 0.8-1.2 mg./kg. for 7-10 days	**Resistant/ Moderately Severe** Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	**Serious/ Life-Threatening** up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover, may result in additive toxicity. Monitoring of vestibular, cochlear and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin in gram-negative urinary and pulmonary infections, Arch. Int. Med. *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., and Smith, J. K.: Gentamicin in the treatment of pulmonary infections, J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a new aminoglycoside antibiotic: Clinical and laboratory studies in urinary tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clinical experience with gentamicin, data from 12 German clinics, in Gentamicin: First International Symposium, Paris, January 1967, Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Laboratory and clinical investigation of gentamicin, *ibid.*, pp. 62-74. (6) Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, H.: Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommended in Package Insert.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

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My in-laws are great.
The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance; with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has baen reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition. Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® · EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® (strip pack), Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

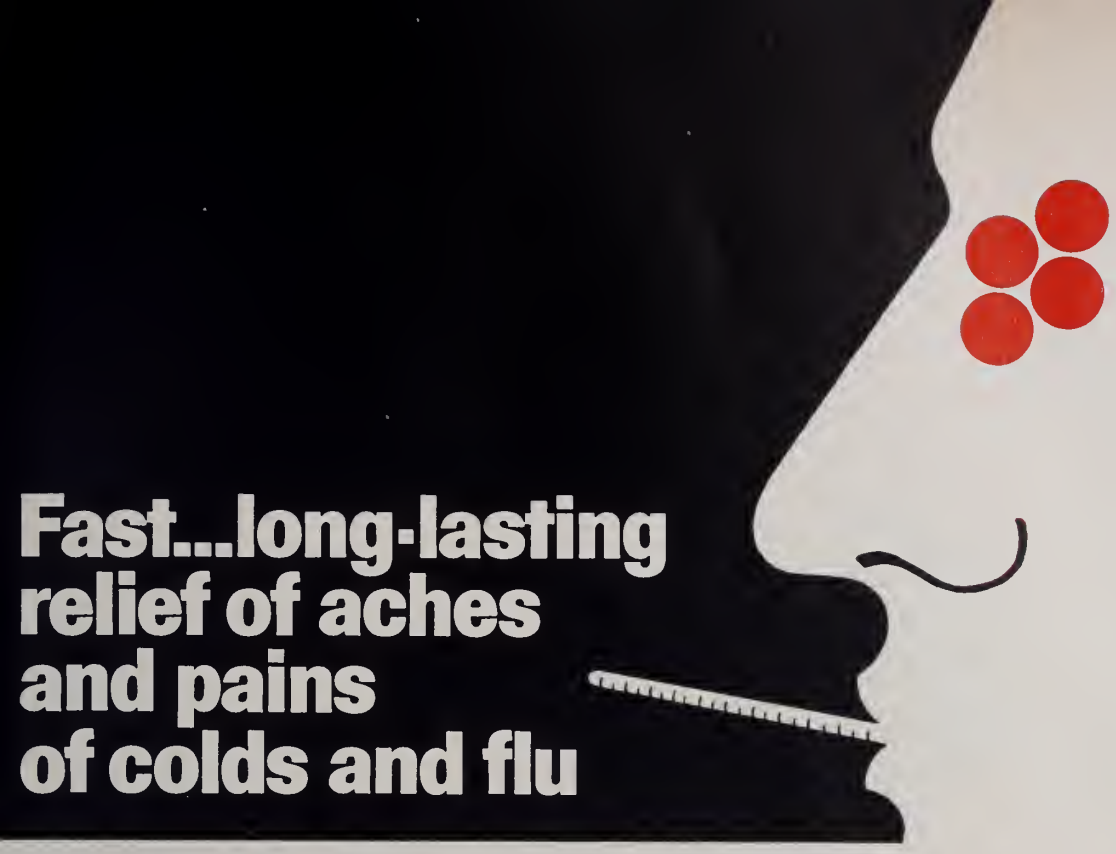
The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

Equanil®
(meprobamate)
Wyeth Laboratories
Philadelphia, Pa.

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Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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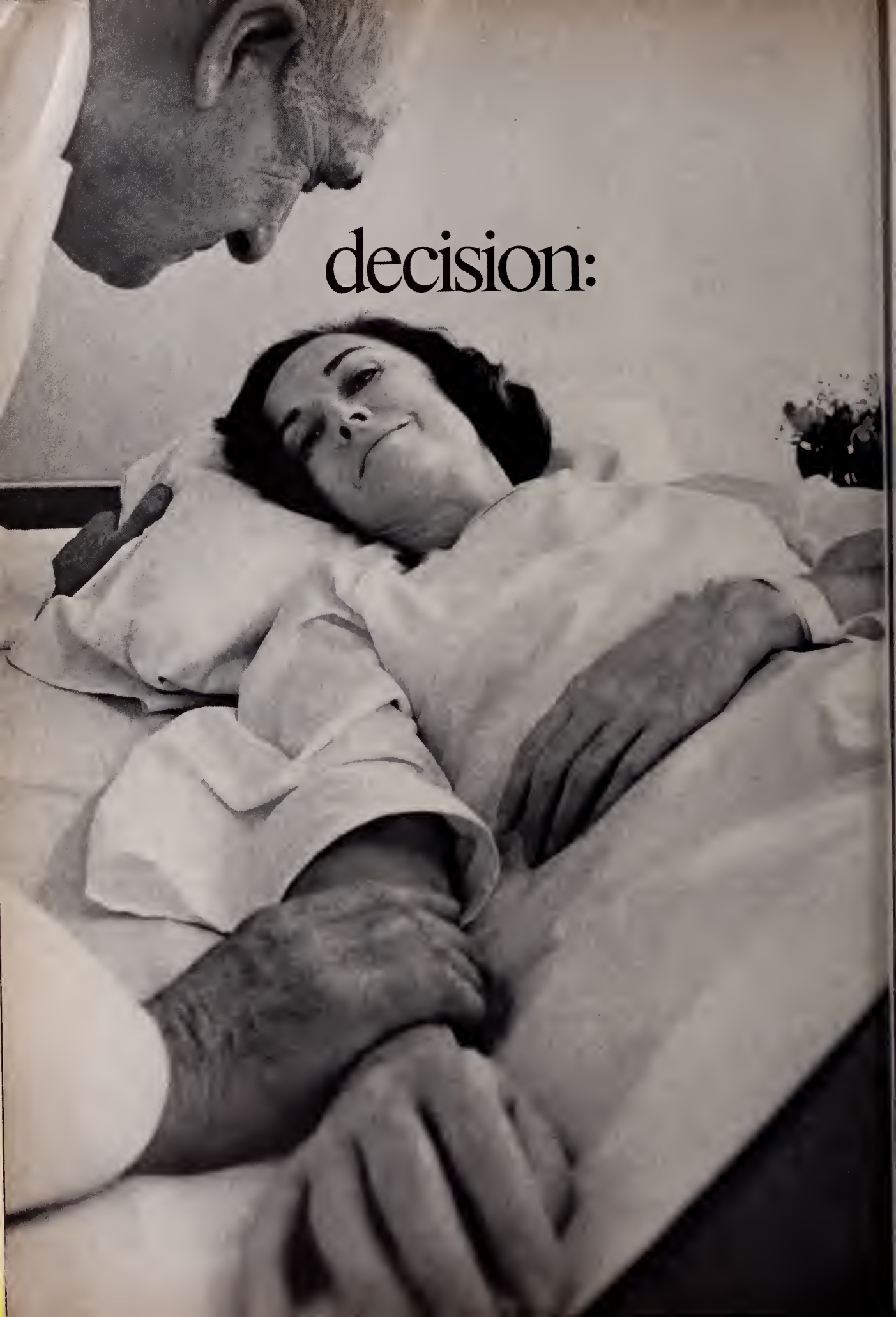
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ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF

Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.

Available: Bottles of 12, 36 and 60 tablets.


decision:

Loridine® I.M.
Cephaloridine

1.5 to 3 Gm. daily successfully treats many moderately severe infections*

- bactericidal action in vitro against susceptible organisms causing:
  pneumonia
  urinary tract infections
  septicemia
  abscesses
- broad-spectrum activity
- relatively painless I.M. injection

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

Lilly 000903

Loridine®
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Loridine®
CEPHALORIDINE



Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

Additional information available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

000903

The girth control pill



Tepanil® Ten-tab

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Controindicotions: Concurrently with MAO inhibitors, in potients hypersensitive to this drug; in emotionally unstoble potients susceptible to drug obuse.

Worning: Although generally sofer than the omphetamines, use with great caution in patients with severe hypertension or severe cordiovoscular disease. Do not use during first trimester of pregnoncy unless potential benefits outweigh potentiol risks.

Adverse Reoctions: Rorely severe enough to require discontinuotion of therapy, unpleasant symptoms with diethylpropion hydrochloride hove been reported to occur in relotively low incidence. As is characteristic of sympothomimetic ogents, it moy occasionally couse CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression hos been reported. In o few epileptics an increase in convulsive episodes hos been reported. Sympothomimetic cardiovascular effects reported include ones such as tachycordio, precordial poin, arrhythmio, palpitation, ond increased blood pressure. One published report described T-wove chonges in the ECG of o heolthy young mole ofter ingestion of diethylpropion hydrochloride; this was on isoloted experience, which hos not been reported by others. Allergic phenomena reported include such conditions os rosh, urticorio, ecchymosis, and erythemo. Gastraintestinal effects such os diorrheo, constipotion, nausea, vomiting, ond obdominol discomfort hove been reported. Specific reports on the hematopoietic system include two eoch of bone morrow depression, ogranulocytosis, ond leukopenia. A voriety of miscelloneous odverse reoctions hove been reported by physicions. These include complaints such os dry mouth, headoche, dyspneo, menstrual upset, hoir loss, muscle poin, decreosed libido, dysurio, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets· One 75 mg. tablet doily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. toblet three times daily, one hour before meols. If desired, an oddition ol toblet may be given in midevening to overcome night hunger. Use in children under 12 yeors of oge is not recommended.

T-006A / 1/70 / U S PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

091SA 1/74

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Hard to believe... a natural beauty spot like this... within easy weekend commuting distance. But it's here atop the Pocono Mountains. A 2½-mile long private lake, undisturbed by power boating, set in 20,000 wooded acres.

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500 mg. capsules maintain optimal levels around-the-clock on b.i.d. dosage

When Vitamin C is taken in ordinary tablet form, the rise in blood levels is rapid, but Vitamin C is as rapidly excreted and blood levels drop accordingly.

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CEVI-BID maintains optimal blood levels of Vitamin C, and avoids "peak and valley" effects of ordinary Vitamin C tablets.

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you can hang on for a few more minutes, Doctor, m sure I'll sneeze again."

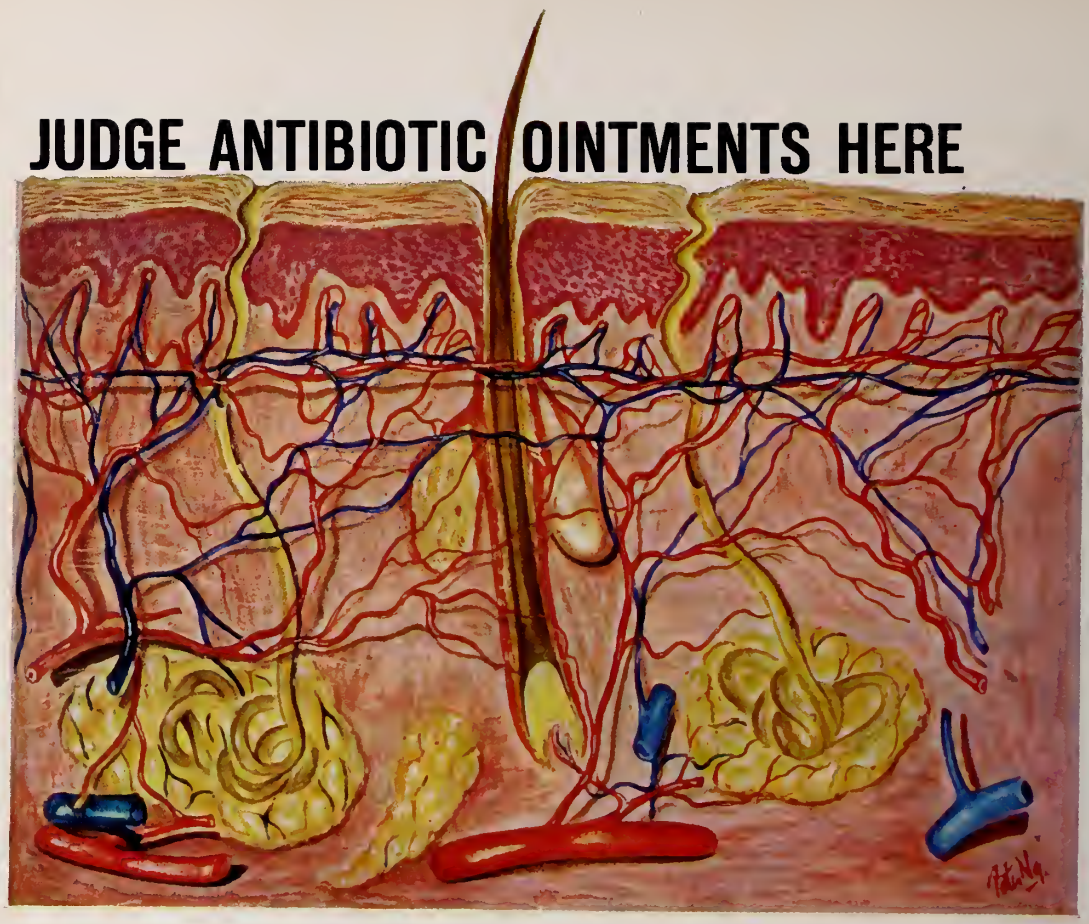
sneeze. And sneeze some more. But with Novahis- LP, most patients get prompt and long-lasting from the symptoms of allergies and colds. These nuous-release tablets have a vasoconstrictor-anti- mine formulation that begins working in minutes, continues to provide relief for hours. Even when congestion is due to repeated allergic episodes, Novahistine LP tablets, morning and evening, let most patients breathe freely all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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brand

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400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS . . . *the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

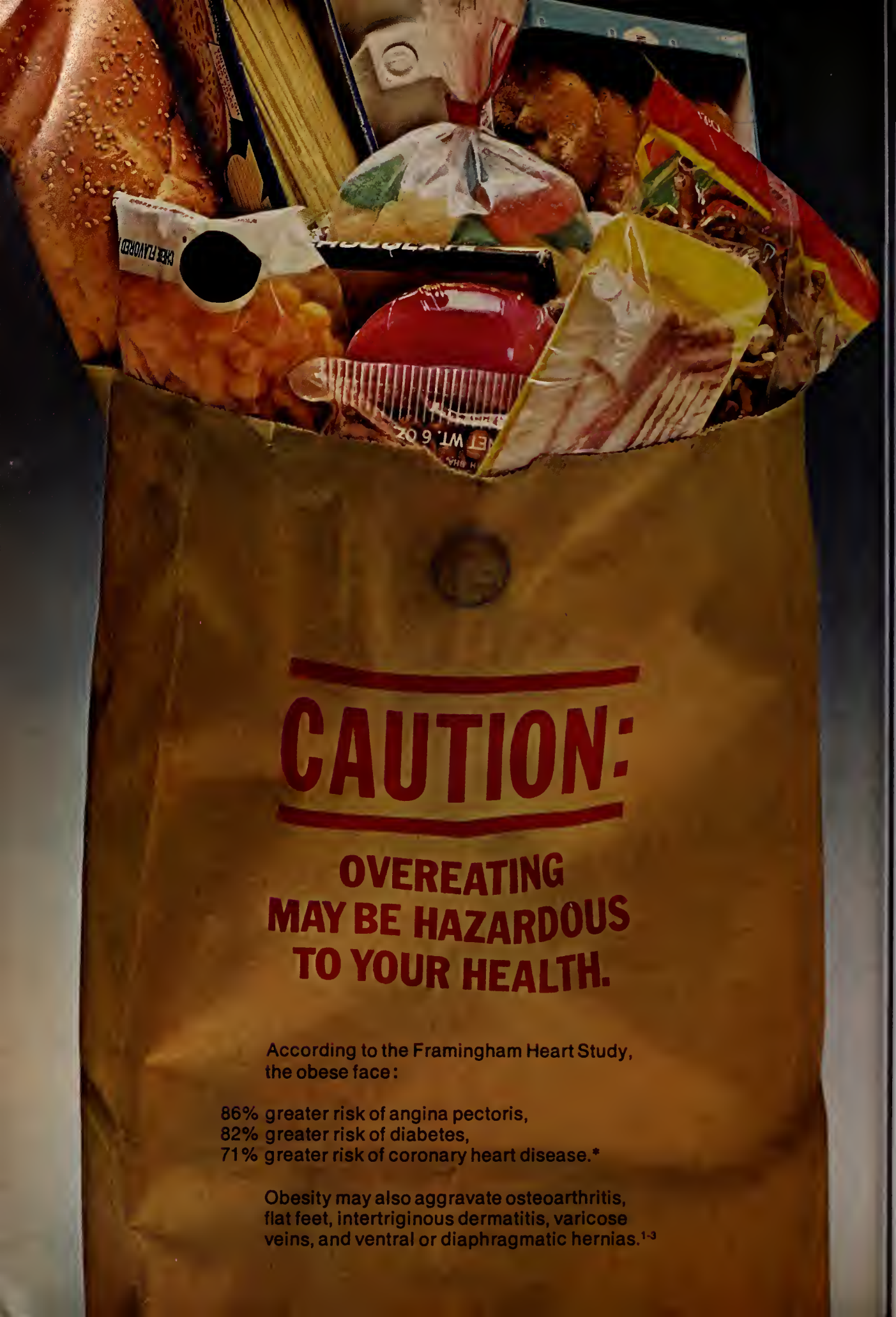
SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 100 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between doses rather than lessening the recommended dose is preferable. The prompt direct action allows a minimum of the first suggestion of return of symptom . . . a guide to dosing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct prism and leave a few tablets for a reserve.*

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals


CAUTION:
OVEREATING
MAY BE HAZARDOUS
TO YOUR HEALTH.
According to the Framingham Heart Study,
the obese face:
86% greater risk of angina pectoris,
82% greater risk of diabetes,
71% greater risk of coronary heart disease.*
Obesity may also aggravate osteoarthritis,
flat feet, intertriginous dermatitis, varicose
veins, and ventral or diaphragmatic hernias.[1-3]

If you are considering weight reduction, consider

Preludin®
phenmetrazine hydrochloride
Endurets®
prolonged-action tablets

Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

Long acting

Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

Once-a-day dosage

One Endurets tablet after breakfast. It helps reduce weight and costs, conveniently.

For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

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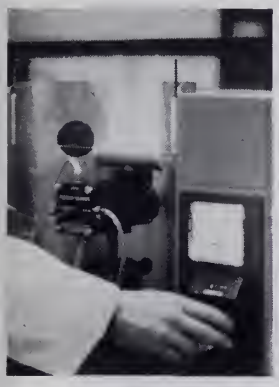
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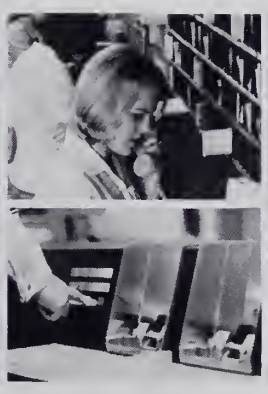
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EDITORIALS

Therapeutic Optimism

At the turn of the century, there were therapeutic nihilists. But today that has all changed. Today's manufacturing pharmacologist is a purveyor of a promise, indeed a salesman of a ticket to Utopia — one way or round trip, as you wish. From his magic vat, he will mix us a stimulant to give energy or virility, a sedative to soothe us; a magic carpet that will waft us to a dream world, and an anti-hallucinogen which will bring us back to earth; an appetizer so that we may eat heartily, combined with a metabolizer so that we will not gain weight. He will cook us a concoction that will make us feel pleasantly high and a swift-acting soberizer that will rescue us from the DTs. He offers us tranquility when we want it and stimulation when we have had enough tranquility. Soon he will send the detailman to tell us of a slow-release capsule that will, for a week-end, give us in proper order the stimulant, the aphrodisiac, the sedative, the anti-hangover product, the tranquilizer, the hypnotic, and then the pep pill. The old magic vanishes to give way to the Keeper of the Benzene Ring, the late twentieth century Merlin who from his beaker, retort, and cauldron will brew for us the best of the beatitudes.

Always we seek the one who can give us blessings. To some, the great blessing is serenity; to others it is excitement. Some want peace, some want thrills. Some want but to sleep, others want the energy to do everything except sleep. Some want life's pace to be speeded and others want it to slow down. Some want to eat heartily and enjoy every morsel; others prefer drinking but want to neutralize the hangover. Some want conscience and consciousness sharpened; others want them blunted. So we look forever for the person, the force, or the spirit who can give us these blessings; each according to his own peculiar calculus of Heaven and Hell. We have sought these desiderata in the past from priests both high and low, from kings and emperors, from wits and wizards and witches, from magicians and from magis, from demagogues and demigods. We have sought such blessings in the rites of nature and in the rites of the supernatural. We have sought them through prayer and through poetry. We have never attained them for this is, it seems, like all promised lands, more promise than performance. It was, as the Hobo's Song puts it, "the big rock candy mountains where the jails are made of tin; and you can bust right out again, as soon as they put you in."

The Three Kings of Cologne yield to the creative chemist, the modern Melchior, Gaspar, and Balthasar who promise to lay at our feet gifts beyond the dreams of the original Magi. And maybe they will do it, at that.

Decorum And Dignity In The Hospital

The headlong flight into informality and togetherness which characterizes our age has brought with it a consequent tarnish to that patina of quality: good manners. Deplorable when encountered in streets and shops, this slippage is particularly regrettable when displayed about our hospitals.

Time is not so far distant when the attending staff set a high tone of dignity to our institutions, one that rubbed off successively on everyone. One need not go back to those late Victorian doctors to find that pleasing virtue —it lies beneath the surface of us all.

Should our hurried and harried lives rob the seriousness of our work of its aura of quality? We think not, but some lifting by the bootstraps is in order. On your next hospital visit, make some comparisons.

Is the nurses' station a business-like place or has it deteriorated into a gossip center, a first-

name based smoking room, a home away from home? This station is often a point of contact with patients' relatives and friends, and an impression made here is lasting.

The patient in room 10 is not "that gallbladder" — his name is Mr. Antrobus, and criticism of his food tray or his nursing care is not to be made in his presence or in the presence of others. A decent respect for the feelings of others is basic. Curtain lectures are given behind drawn curtains.

Are we so weary that we must sit on the patient's bed?

Irritability, like a lady's slip, should never show. It is a fault in self-discipline, easily corrected. The place for the latest story is in the cloakroom. Good manners will have a rebirth when we regard everyone involved in the patient's care and comfort as a respected and trusted colleague but *not* as a bosom pal.

The practice of medicine is a serious calling. We must not permit it to be vulgarized.

— From the New York State Journal of Medicine.

The Worthy Patient

Remember when we used to speak of the "worthy poor," presumably to distinguish them from the "unworthy" poor? In our present state of grace, we shun this kind of moralistic judgement. Indeed in the 1955 edition of the *AMA Principles of Medical Ethics* it is written (chapter I, section 2) that physicians "must dispense the benefits of their special attainments in medicine to all who need them." (Not, to all who "deserve" them). Only two years later, when the 1957 *Principles* were adopted this sentence was reworded to: ". . . should make available to their patients and colleagues the benefits of their professional attainments." The phrase, "all who need them," seems to have been omitted. But it is hard to believe that this omission was a repudiation of the idea that medical care must be available to all who *need* it.

Many of us, however, somehow cling to the notion that certain types of illness are *not* worthy of all our efforts. It is not unknown for nurses and attendants to treat rather curtly the obstetrical needs of unmarried women. Many a doctor has scant sympathy for the alcoholic, and even the wildest case of delirium tremens doesn't bring forth quite the same dedication as the delirium of a pneumonia. Beneficiaries of the care in free clinics constantly complain about a shabbiness of treatment and a curtness of care which, true or not, indicates the impression that these poor people get. And probably this is a reflection of our feeling that people who are poor or on welfare are just not good, solid, responsible people. And, we sometimes act as if we thought that the syphilitic patient is just being punished for his sins.

This last example lights up another type of "unworthy" patient — the one whose disability was brought on by his own carelessness — not necessarily an evil or vicious practice, but just a careless or irresponsible one. We all know better but many of us are annoyed at being asked to give intensive, first rate care to people who have bungled their own suicide attempts (and given us so much trouble — when it's all their own fault), or to give a lot of care to the heroin addict who brought about his own hepatitis by using a dirty needle for self-injection.

Chronic illness, even in "worthy" people, leads to a shortening of the adjective "chronic" to the pejorative noun "crock." And some of us don't give "crocks" as much devoted and dedicated attention as we give to "interesting" and acute cases.

Nobody, of course, will defend a two-class system (worthy and unworthy) of medical patients, but sometimes we ought to review our own attitudes in these difficult cases. Let us make sure that we adhere to the canon that we must give the benefits of our skill to "all who need them"—worthy or not.

Official Transactions Of the House of Delegates

204th ANNUAL MEETING
MAY 16-19, 1970

THE MEDICAL SOCIETY OF NEW JERSEY

NOTE TO READERS

The annual reports and transactions of the House of Delegates of the 204th Annual Meeting of The Medical Society of New Jersey are bound together in this issue of THE JOURNAL. Actions taken by the House of Delegates are indicated in boldface small type.

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ANNUAL REPORTS

President

Nicholas A. Bertha, M.D., Wharton

(Reference Committee "A")

My year as President has been, not unpredictably, a mixture of satisfactions and dissatisfactions, of hopes and fears, of strivings and accomplishments. No one can serve in this office without realizing how complex are the relationships of our organizational life, how increasingly numerous and significant are our problems, and how tremendously important and helpful are the contributions made by all our officers, members, and staff in the furtherance of the basic goals and the transaction of the ordinary and extraordinary business of The Medical Society of New Jersey.

I have never had a busier or more interesting period in my life. Our own intra-Society meetings and conferences are many; with the exception of the Judicial Council, the president is a member of all councils and committees. But our liaison relationships and our necessary and beneficial cooperative contacts with other agencies and groups — governmental, professional, and civic — are equally numerous and demanding.

It was a pleasure for me to visit and take part in the annual meetings of neighboring state medical societies. Everywhere I went I basked in the reflected esteem in which our Society is held, and although the annual meetings which I attended were, in the main, well programmed and ably conducted, I had the happy conviction that our own annual meetings are outstanding in scope, schedule, and efficiency.

Naturally, we of the Society played a lively part in the frequent negotiations and discussions, with representatives of the Department of Institutions and Agencies and of the Prudential Insurance Company, connected with the establishment and operations of the Medicaid Program and the continuing success of the program in New Jersey. We succeeded in achieving the adoption of physicians' usual and customary fees as the basis for compensation under the program. It is evident that as the program proceeds continuing negotiations are inevitable, in the light of developing experiences and the always present specter of limitation of funds. However, the attitudes of the representatives of the Department have been both understanding and cooperative. I have every confidence that, if we can retain the present climate of reasonableness, we will be able to work out solutions that will continue to be mutually acceptable.

It is a natural temptation in a report such as this to be over-detailed. To avoid this defect, I offer summary assurance that in public and private hearings we have clearly set forth for the record the positions and thinking of The Medical Society of New Jersey on such subjects as sex education in the public schools, extended insurance coverage under Blue Cross and Blue Shield for the complications of pregnancy, a subscription rate increase for Blue Cross, and various legislative bills and proposals of vital medical interest.

It was particularly gratifying to me to be able to visit many of our component societies. Uniformly I was given red-carpet treatment, and officers and members displayed keen interest in, and genuine appreciation of, the many challenging matters that confront us. At all such meetings I urged on those present, as now I urge on all who read this report, recognition that these times demand the best

that we all, individually and collectively, can supply in the way of thought and action. We need a great infusion of idealistically dedicated and right-thinking members, especially from among the ranks of our younger colleagues, to give themselves to the work of the Society for the preservation of the best that medicine has developed and offers and for the advancement of the true welfare and well-being of our people.

The prevailing popular impression of the character and worth of the profession of Medicine at any time will always be a distillation of the prevailing impression of the character and worth of the men and women who are its members. It is not sufficient for us as individuals to exact of ourselves command of the science of Medicine, by participating in continuing medical education and keeping ourselves informed concerning new developments and discoveries. It is equally if not more important that we constantly remember that the practice of Medicine is an art and that our success as practitioners, and Medicine's good name, will flourish only to the extent that, and as long as, we do not compromise the standards of our art.

This is an exhortation I have frequently made to the groups of our members whom I have in the course of the year addressed. This is my closing exhortation to all our members, as I submit this final account of my stewardship. Let us be true to our great past and to our best selves, in all that we undertake and do, and then in fact and in deed we will show ourselves to be, in the words of our official motto, "help-bringers throughout the world."

Approved (page 428)



President Bertha receives Fellow's Key from Immediate Past-President Kustrup



His home County Society (Morris, Dr. Kuvin, President) presents engraved watch to President Bertha

Secretary

Charles L. Cunniff, M.D., Jersey City

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

Membership

	(As of December 31, 1969)		
Active:	Paid	6,628	
	Exempt	499	7,127*
Associate:	Paid	498	
	Exempt	48	546*
State Emeritus			210
State Honorary			9
New and Reinstated Members:			
	Active	182	
	Associate	325	507
Transfers within the state			33
Transfers out-of-state and resignations			73
Members deceased			103
Members dropped:			
	Active (non-payment of dues)	29	
	Associate (non-payment of dues)	7	36

AMA Membership

A total of 6,149 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total seven delegates—one for each thousand members, or fraction thereof.

Membership Directory

Work is being carried forward to achieve the publication of the next edition of the *Membership Directory* in the fall of 1970, when, it is expected, distribution will be made to the entire membership.

The new *Directory* will embody the same features as those of the 1968-69 edition. These include: (1) the presentation in bold print of the "type of practice" in the individual listing directly following the name, and preceding the address; (2) a single asterisk (*) to designate "Armed Forces," a single dagger (†) to designate associate, and a double dagger (††) to designate emeritus membership; (3) the zip code will appear as the last item in each individual listing; (4) the hospital section of the Directory will again include the listings of hospital staffs; (5) the special membership supplement section—which now includes the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Basic Concepts Underlying the Provision of Professional Medical Care, Legal Obligations Affecting Medical Practitioners in New Jersey, and a list of Poison Control Centers in New Jersey—will also include Guides for Physicians-Hospital Relationships in New Jersey.

Verification data sheets supplied to the membership will form the basis for the biographical data to be published in the 1970-71 edition, as did similar data sheets which were supplied to publish the 1968-69 *Directory*. With the cooperation of the membership, it is the hope of your committee to make this forthcoming *Directory* the most complete and accurate edition yet published.

Approved (page 428)

* Adjusted for transfers out-of-state, resignations, and deaths.

Treasurer

Samuel J. Lloyd, M.D., Trenton

(Reference Committee "B")

This 1970 interim report of your Treasurer has been prepared from the books and records of The Medical Society of New Jersey by the Society's independent certified public accountants.

The Comparative Balance Sheet is presented as of 30 April 1970 and 30 April 1969 without audit or opinion, for the reason that the current fiscal year of the Society does not end until 31 May 1970. Audited figures and a report of audit will be prepared and submitted for the year ended 31 May 1970 at a subsequent date.

The Comparative Statement of Revenue, Expenditures and General Surplus Unappropriated present the transactions of the Society for the eleven month periods ended 30 April 1970 and 30 April 1969.

Revenues have been checked, by the auditor, in full for the period and disbursements checked to supporting approved vouchers. The cash balances at 30 April 1970 were reconciled with the bank statements but were not confirmed direct with the depositories. Revenue from Counties for dues assessments were checked in detail to reports on file, but were not confirmed with the County Treasurers at this time. Investments were not physically examined.

These interim statements have been prepared in a form similar to the audited annual report, in order to show in greater detail the assets, liabilities and fund balances, operating revenue, and expenditures of the Society, in conformity with Resolution #28 approved by the 1968 House of Delegates under the heading "Annual Financial Report."

GENERAL FUND
COMPARATIVE BALANCE SHEETS

ASSETS	*April 30* *1970*	*1969*
Cash (Page 313)	$111,845.37	$124,653.87
Investments—at cost (Page 314)	425,466.62	398,396.49
Accounts Receivable	7,030.16	9,379.63
Inventories:		
Maternal Service Record Books (contra)	3,115.31	3,847.44
"The Healing Art" books (contra)	8,506.96	8,566.21
Land, buildings and equipment (contra)	165,215.36	164,988.76
Accrued interest and other assets	8,569.11	5,767.07
Total Assets	$729,748.89	$715,599.47

LIABILITIES, SPECIAL FUNDS AND GENERAL SUPPLIES UNAPPROPRIATED

Liabilities:		
Unexpended budget appropriations (Page 309)	$ 88,356.20	$ 71,024.44
American Medical Association (Page 313)	280.00	———
Library of Academy of Medicine (Page 313)	25.00	35,892.50
Journal Publication	5,000.00	4,787.61
Other Liabilities	3,269.74	3,480.17
Special Funds:		
Provision for losses of Medical Journal	10,000.00	———
Assessments deferred to future operations (Page 312)	208,478.38	188,425.62
Membership Directory	3,077.00	———
Annual Meeting	24,570.57	25,551.31
"The Healing Art" (contra)	8,506.96	8,566.21
House Restoration and Replacement	6,960.74	6,670.14
Maternal Service Record Books (contra)	3,115.31	3,847.44
Land, buildings and equipment (contra)	165,215.36	164,988.76
AMA Grant for Psychiatry Symposium	———	750.00
General surplus unappropriated (Page 310)	202,893.63	201,615.27
	$729,748.89	$715,599.47

STATEMENT OF EXPENDITURES—GENERAL FUND
For the Eleven Months Ended 30 April 1970

	Adopted Budget	*Total Expended*	*Balance Unexpended*
Administrative and Executive:			
Executive Salaries	$ 61,270.40	$ 55,791.75	$ 5,478.65
General Staff Salaries	103,919.97	86,978.95	16,941.02
General Executive Office Expenses	16,000.00	12,550.93	3,449.07
Executive Travel	3,000.00	2,245.81	754.19
House Maintenance	19,000.00	16,332.23	2,667.77
Treasurer	5,800.00	5,275.48	524.52
Finance and Budget Committee	75.00	5.70	69.30
Secretary	450.00	4.38	445.62
Employment Security Taxes	1,310.00	1,266.34	43.66
Federal Insurance Contributions	5,700.63	5,463.71	236.92
Federal Unemployment Insurance	280.00	272.54	7.46
Insurance	8,810.00	8,317.16	492.84
House Reserve	6,600.00	1,850.08	4,749.92
Welfare:			
Legislation Council	8,800.00	5,406.14	3,393.86
Public Health Council	2,650.00	1,035.82	1,614.18
Public Relations Council	6,800.00	3,845.18	2,954.82
Medical Services Council	700.00	215.25	484.75
Mental Health Council	1,450.00	300.93	1,149.07
Special:			
President & Presidential Officers	14,960.00	12,848.07	2,111.93
AMA Delegates	8,400.00	7,138.19	1,261.81
Woman's Auxiliary	3,175.00	2,768.70	406.30
Medical Education Committee	35,150.00	17,522.10	17,627.90
Conference Groups	500.00	37.16	462.84
Membership Directory	15,000.00	11,661.70	3,338.30
Emergency Medical Care Committee	325.00	67.12	257.88
Credentials & Membership Committee	350.00	346.24	3.76
Archives & History	100.00	———	100.00
Project Hope—Vietnam	6,000.00	2,000.00	4,000.00
Medical Defense & Insurance Committee	500.00	161.88	338.12
Other:			
Board of Trustees	6,150.00	1,844.70	4,305.30
Contingent	10,000.00	5,606.03	4,393.97
Judicial Council	550.00	122.72	427.28
Legal	6,300.00	4,750.00	1,550.00
Health Facilities Planning Council	5,000.00	5,000.00	———
Medical Student Loan Fund	5,000.00	5,000.00	———
Reimbursement for Representatives to Meetings	3,500.00	1,186.81	2,313.19
Total Budget Expenditures	$373,576.00	$285,219.80	$ 88,356.20

COMPARATIVE STATEMENT OF REVENUE EXPENDITURES AND GENERAL SURPLUS UNAPPROPRIATED

	For the Eleven Months Ended 30 April	
	1970	*1969*
Revenue:		
Assessments Earned (Page 312)	$357,175.09	$298,763.41
Income on Savings Accounts (Page 313)	2,701.26	2,700.00
Income on Investments (Page 314)	18,301.78	13,219.29
Maternal Service Record Book Sales	673.09	644.52
Miscellaneous Income	69.34	20.44
Total Revenue	$378,920.56	$315,347.66
Less Approved Budget for Year (Page 309)	373,576.00	316,266.00
Excess of Revenue over Approved Budget (deficit)	$ 5,344.56	$(918.34)
Deduct Medical Journal Deficit (Page 310)	24,811.62	16,484.70
Net Deficit	$ 19,467.06	$ 17,403.04
Transfers and Adjustments to Surplus—net	198.78	4,344.65
	19,268.28	21,747.69
General Surplus Unappropriated:		
Balance, June 1	$222,161.91	$223,362.96
Balance, April 30	$202,893.63	$201,615.27

COMPARATIVE STATEMENT OF REVENUE AND EXPENDITURES—MEDICAL JOURNAL

	For the Eleven Months Ended 30 April	
	1970	*1969*
Revenue:		
Advertising:		
State Medical Journal Advertising Bureau	$ 36,265.57	$ 39,498.74
Local	11,473.09	10,642.13
Cooperative Rebate	2,172.86	2,683.35
Classified	454.80	792.10
Subscriptions and Extra Copies	1,624.36	1,188.24
Illustrations	606.16	611.94
Reprints—net	1,132.85	1,215.00
Total Revenue	$ 53,729.69	$ 56,631.50
Expenditures:		
Publication	$ 52,283.45	$ 50,050.82
Salaries	14,120.00	12,010.64
Advertising Manager's Commission	4,892.62	4,638.81
Commissions—Local	2,886.15	2,844.42
Discounts	898.32	980.50
Administrative Expenses	1,154.41	917.72
Payroll Taxes	830.40	661.06
Insurance	338.55	243.10
Travel	216.63	10.40
Illustration Expense	898.72	635.74
Office Expenses	22.06	122.99
Total Expenditures	$ 78,541.31	$ 73,116.20
Excess of Expenditures over Revenue	$ 24,811.62	$ 16,484.70

MEDICAL STUDENT LOAN FUND
COMPARATIVE BALANCE SHEETS

ASSETS	*30 April 1970*	*1969*
Cash (Page 311)	$ 38,343.08	$ 47,523.53
Investments—at cost (Page 314)	111,728.70	97,120.23
Notes Receivable	190,369.00	177,294.00
Accrued Interest	1,044.33	740.95
Fund Balance	$341,485.11	$322,678.71

Note: The fund balance includes $6,312.00 designated as the A. Barker Kump Memorial Grant and $5,030.00 designated as the Joseph E. Mott Memorial Grant.

MEDICAL STUDENT LOAN FUND
COMPARATIVE STATEMENT OF REVENUE AND FUND BALANCE

	30 April 1970	*1969*
Revenue:		
Contributions:		
General	$ 3,484.52	$ 3,449.43
Budget Appropriation from General Fund	5,000.00	———
Special Assessment of Membership	———	7.50
Income from Investments (Page 314)	6,473.85	4,727.72
Interest on Savings Accounts (Page 313)	1,273.03	1,199.87
Interest on Notes Receivable	252.39	355.23
Total Revenue	$ 16,483.79	$ 9,739.75
Bad Debt Recovered (charged off)	140.00	(225.00)
Net Revenue	$ 16,623.79	$ 9,514.75
Fund Balance:		
June 1	324,861.32	313,163.96
April 30	$341,485.11	$322,678.71

SCHEDULE OF STATE ASSESSMENTS COLLECTED
For the Eleven Months Ended 30 April 1970

County	*1970 Dues*	*1969 Dues*	*Net State Assessments*
Atlantic	$ 8,635.00	$ 216.67	$ 8,851.67
Bergen	43,651.88	1,358.39	45,010.27
Burlington	9,313.38	175.02	9,488.40
Camden	21,541.71	308.35	21,850.06
Cape May	2,016.68	———	2,016.68
Cumberland	5,206.68	———	5,206.68
Essex	75,845.20	3,308.34	79,153.54
Gloucester	4,711.70	66.68	4,778.38
Hudson	24,236.79	1,433.38	25,670.17
Hunterdon	2,860.03	116.69	2,976.72
Mercer	19,103.42	1,558.33	20,661.75
Middlesex	20,771.85	700.03	21,471.88
Monmouth	18,168.40	1,733.36	19,901.76
Morris	19,286.78	916.66	20,203.44
Ocean	5,610.03	583.32	6,193.35
Passaic	30,873.40	616.69	31,490.09
Salem	2,255.00	———	2,255.00
Somerset	5,371.69	408.32	5,780.01
Sussex	2,145.01	16.67	2,161.68
Union	33,586.87	725.00	34,311.87
Warren	2,200.01	33.34	2,233.35
Total	$357,391.51	$14,275.24	$371,666.75

RECONCILIATION OF STATE ASSESSMENT ACCOUNT
For the Eleven Months Ended 30 April 1970

Unearned Assessments, 31 May 1969		$193,986.72
Net Assessments collected for period per schedule above		371,666.75
Earned Assessments for year ended 31 May 1970:		
1969 Unearned Assessments at 31 May 1969	$193,986.72	
1969 Assessment Collections	14,275.24	
1970 Assessment Collections Applicable (5/12 of $357,391.51)	148,913.13	
Earned Assessments for period	$357,175.09	
Unearned Assessments at 30 April 1970:		
Assessments Applicable to year ended 31 May 1971 (7/12 of $357,391.51)	208,478.38	
Total	$565,653.47	$565,653.47

SCHEDULE OF SPECIAL ASSESSMENTS COLLECTED
For the Eleven Months Ended 30 April 1970

County	*American Medical Association Dues*	*Library of Academy of Medicine Assessments*
Atlantic	$ 10,710.00	$ 20.00
Bergen	36,330.00	245.00
Burlington	10,080.00	45.00
Camden	25,760.00	45.00
Cape May	2,240.00	———
Cumberland	5,390.00	———
Essex	80,605.00	420.00
Gloucester	5,320.00	20.00
Hudson	24,080.00	200.00
Hunterdon	3,220.00	15.00
Mercer	23,625.00	200.00
Middlesex	22,260.00	140.00
Monmouth	15,820.00	210.00
Morris	21,210.00	145.00
Ocean	6,650.00	75.00
Passaic	23,450.00	120.00
Salem	2,870.00	———
Somerset	5,775.00	55.00
Sussex	2,310.00	10.00
Union	39,410.00	75.00
Warren	2,590.00	10.00
Total	$369,705.00	$2,050.00

SCHEDULE OF SPECIAL ASSESSMENT ACCOUNTS
For the Eleven Months Ended 30 April 1970

	American Medical Association	*Library of Academy of Medicine*	*Medical Student Loan Fund*
Balance payable, 31 May 1969	$ ——	$ 520.00	$15.00
Assessments collected per above	369,705.00	2,050.00	——
	$369,705.00	$2,570.00	$15.00
Remitted to Organizations	369,425.00	2,545.00	15.00
Balance payable, 30 April 1970	$ 280.00	$ 25.00	$——

ANALYSIS OF CASH, SAVINGS ACCOUNTS AND INCOME THEREON

		Balance 30 April 1970	*Rate of Interest*	*Interest Income*
General Fund:				
First Trenton National Bank				
Treasurer's General Account	$54,345.37			
Executive Account	12,000.00			
Office Petty Cash Fund	500.00			
Certificate of Deposit	15,000.00	$ 81,845.37	5%	$ 750.00
First National Bank of Spring Lake				
Certificate of Deposit		15,000.00	5%	750.00
First Camden National Bank & Trust Co.				
Certificate of Deposit		15,000.00	5%	750.00
Total		$111,845.37		
Income from Savings and Loan Association —account withdrawn during period				451.26
Total Interest				$2,701.26
Medical Student Loan Fund:				
First Trenton National Bank				
Treasurer's Checking Account		$ 8,343.08		
Savings Account		15,000.00	4½%	616.77
United Savings & Loan Association				
Trenton, New Jersey—Savings Account		15,000.00	4¾%	656.26
Total		$ 38,343.08		$1,273.03

SCHEDULE OF INVESTMENTS AND INCOME EARNED
30 April 1970

Description	*Basis*	*Cost*	*Maturity Value*	*Interest Income*
General Fund:				
U. S. Treasury Bills, due 5/31/70	7.00	$ 34,319.44	$ 35,000.00	$ 469.59
U. S. Treasury Bills, due 6/18/70	7.92	28,798.50	30,000.00	878.10
U. S. Treasury Bills, due 7/30/70	7.77	67,248.30	70,000.00	1,425.83
U. S. Treasury Bills, due 8/20/70	6.91	33,796.05	35,000.00	462.70
U. S. Treasury Bills, due 9/24/70	6.18	29,082.20	30,000.00	176.40
U. S. Treasury Bills, due 9/30/70	6.72	33,634.53	35,000.00	365.68
U. S. Treasury Bills, due 10/22/70	6.49	29,035.10	30,000.00	37.10
Bank for Cooperatives, due 10/1/70	7.45	20,000.00	20,000.00	122.40
Federal Intermediate Credit Bank Debentures, due 10/1/70	8.80	30,000.00	30,000.00	701.31
Federal Intermediate Credit Bank Debentures, due 1/4/71	7.50	20,087.50	20,000.00	110.91
Southern Railway Equipment Trust Certificates, due 3/1/71	6.00	20,000.00	20,000.00	1,100.00
Federal National Mortgage Association, due 4/8/71	6.30	20,000.00	20,000.00	1,155.00
Southern Railway Equipment Trust Certificates, due 11/1/72	6.95	19,465.00	20,000.00	1,122.92
Great Northern Railway Equipment Trust Certificate, due 3/1/73	6.00	20,000.00	20,000.00	1,100.00
Export-Import Bank Debentures, due 4/30/73	6.15	20,000.00	20,000.00	1,127.50
Total Investments		$425,466.62	$435,000.00	
Income from Investments Redeemed during the period				7,946.34
Total Interest on Investments				$18,301.78
Medical Student Loan Fund:				
U. S. Treasury Bills, due 6/18/70	6.83	$ 19,674.40	$ 20,000.00	$ 150.36
U. S. Treasury Bills, due 6/25/70	6.26	19,703.40	20,000.00	114.10
U. S. Treasury Bills, due 7/23/70	7.66	33,644.10	35,000.00	730.10
U. S. Treasury Bills, due 10/22/70	6.49	38,706.80	40,000.00	49.77
Total Investments		$111,728.70	$115,000.00	
Income from Investments Redeemed during the period				5,429.52
Total Interest on Investments				$ 6,473.85

Approved with commendation to the Treasurer on the excellence of his report (page 429)

Board of Trustees

Thomas C. DeCecio, M.D., Chairman, Cliffside Park

(Reference Committee "A")

All significant actions taken by the Board of Trustees at regular meetings held in the course of the year now closing have been reported in *The Journal* and have thus been called to the attention of the general membership. In addition, full copies of all Board minutes are transmitted to component societies, for reference and report at county meetings. In this report, therefore, it seems necessary and desirable to emphasize by specific mention only those items of particular significance that are not reflected elsewhere in the individual reports of councils and committees.

Since its last report to the House, a total of 11 meetings of the Board will have been held. Board attendance at these meetings was excellent; all Trustees served loyally and diligently.

Routinely, the Board has dealt with matters of all kinds arising out of its responsibilities or brought to its attention, including correspondence and resolutions from members, component societies, the American Medical Association, and outside organizations. It has appointed representatives to local, state, and national meetings of concern to MSNJ; acted on reports and recommendations of the Society's councils and committees; and cooperated with allied organizations and various departments of state government.

Dr. Louis F. Albright of Spring Lake was reelected by the Board to continue serving as its Secretary during the past year. Special commendation is due him for his conscientious performance in processing all Board correspondence and meeting notices.

The Board recorded its profound grief at the death of Dr. Lloyd A. Hamilton, who was a former member of the Board of Trustees. A memorial resolution adopted by the Board during the administrative year will be submitted as the first order of business at the 1970 House of Delegates for concurrence.

The Board of Trustees will have two more meetings before the first session of the House of Delegates. The items from those meetings which must be directed to your attention will be the subject of a supplemental report to the House.

Approved (page 428)

Request to Governor to Appoint a Group to Study State Mental Health Program

(Reference Committee "F")

The 1969 House of Delegates adopted, in amended form, Resolution #21, which called upon the Society to petition the Governor to appoint a group of medical consultants, named with the advice and concurrence of the Society's Board of Trustees, to propose a new structure for mental health care in New Jersey.

The President sent a letter and a copy of the resolution to Governor Hughes under date of 6 June 1969, urging the Governor to act favorably upon the recommendations contained in the resolution and offering assurance of the Society's willingness to cooperate in every way to effectuate the purpose of that resolution.

Under date of 10 June 1969, the Governor acknowledged with thanks the President's communication and indicated that he would be pleased to take the resolution under advisement. Subsequently, the State of New Jersey made an agreement with the American Psychiatric Association to send a team of physicians to make such a study. That team began its investigatory work in the early part of February 1970.

Approved (page 438)

MSP Board of Trustees—Nominations
(Reference Committee "C")

The following nominations were approved by the Board and are referred to the House of Delegates for action:

Not included in this printed list of members serving on the Board of Trustees are the following: Chairman of the Board of Trustees of Hospital Service Plan of New Jersey, President of the New Jersey Hospital Association, and President of The Medical Society of New Jersey. These three people serve during their respective terms of office of the organizations indicated.

Also listed are persons who will continue membership on the Board until the expiration of their terms in the year indicated—or until their successors are elected and qualified:

Approved (page 431)

Three-year term (1970-1973):

Name	Type of Practice	Member of Component Society
Edgar P. Eaton, Jr.	Businessman	—
Edwin T. Ferren, D.O.	General Practice	—
Mortimer J. Fox, Jr.	Businessman	—
Jerome G. Kaufman, M.D.	Internist	Essex County
Joseph M. Keating, M.D.	Obstetrician	Passaic County
Elton W. Lance, M.D.	Surgeon	Union County
Henry J. Mineur, M.D.	Internist	Union County
Stanley C. Van Ness	Lawyer	—
John F. Waters	Labor Leader	—

Terms Expiring 1971	Type of Practice	Member of Component Society
Edwin H. Albano, M.D.	Pathologist	Essex County
James T. Crowley	Businessman	—
Lloyd M. Felmly	Retired Newspaper Editor	—
Samuel J. Lloyd, M.D.	Surgeon	Mercer County
Theron L. Marsh	Banker	—
Jesse McCall, M.D.	Internist	Sussex County
Rudolph C. Schretzmann, M.D.	Obstetrician	Bergen County
Charles O. Tyler, M.D.	Pediatrician	Camden County)
Thomas J. White, M.D.	Internist	Hudson County

Terms Expiring 1972	Type of Practice	Member of Component Society
Donald T. Akey, M.D.	Surgeon	Middlesex County
Robert G. Boyd	Hospital Administrator	—
Joseph A. Cox, M.D.	Anesthesiologist	Union County
Charles L. Cunniff, M.D.	Internist	Hudson County
Andrew P. Dedick, Jr., M.D.	Radiologist	Monmouth)County
Warren H. Simmons, Jr.	Businessman	—
Sidney I. Simon, Ph.D.	College Professor	—
Morgan Sweeney	Labor Leader	—
Robert E. Verdon, M.D.	General Practice	Bergen County

Joint Conference with Presidents of Component Societies
(Reference Committee "A")

The Board continued the precedent of sponsoring, in the fall and spring, informal conferences for presidents and presidents-elect of component societies. A total of 25 presidents and/or presidents-elect represented 16 component societies at the fall conference. This year the spring conference will be held in conjunction with the April meeting of the Board. The meeting was originally scheduled for February, but had to be postponed because of weather conditions.

The various items covered informally in this group have been reported in detail in *The Journal* and thus need not be reflected here.

Approved (page 428)

Professional Liability Panel
(Reference Committee "A")

The Administrative Director of the Courts has rendered a summary report as of 30 January 1970, indicating the Courts' experience in handling claims under the Supreme Court Rule 4:21 (concerning the use of subpanels on professional liability claims).

	1966	1967	1968	1969	Total To Date
Number of claims filed	35	51	40	27	153
Disposition of Claims					
Prior to Subpanel Hearing:					
Consents Refused	9	12	7	5	33
Claims Settled	—	2	—	1	3
Claims Withdrawn	6	10	7	1	24
Hearings Completed:	*20	27	12	7	66
No Basis Found	15	20	9	6	50
Reasonable Basis	6	7	3	1	17
Pending:					
Consents Received	—	—	3	8	11
Awaiting Consents	—	—	11	5	16

* One case had 2 allegations of negligence. Panel found reasonable basis on one count, and no basis on the other.

Recommendation

That the professional liability claims panel program be continued, and that the members of MSNJ be encouraged to continue to cooperate in its furtherance.

Approved (page 428)

MSP-HSP Coverage for Psychiatric Patients
(Reference Committee "C")

The 1969 House of Delegates adopted, in amended form, Resolution #19 (Morris County) which called upon the Society to engage in discussion with the Hospital Service Plan of New Jersey and the Medical Surgical Plan of New Jersey with a view "to provide adequate insurance coverage for patients with psychiatric diagnoses while under the care of a physician."

The proposals were submitted to both Plans, but the climate for favorable discussion and action was dissipated by the fact that the Blue Cross Plan was involved in the protracted processes of its pursuit of permission from the Commissioner of Banking and Insurance to effect a substantial rate increase. The special public defender set his force adamantly against any expansion of benefits for subscribers so as to eliminate any new grounds for further elevation of subscription rates. Consequently, the proposal contained in the resolution could not be implemented.

Approved with recommendation (page 431)

Referrals to the Conference Committee on Inter-Relations with the Judiciary and Bar
(Reference Committee "C")

On the recommendation of Reference Committee "E" the 1969 House of Delegates disapproved Resolutions #9 and #11. Both of these resolutions in large part concern themselves with proposals to reduce the incidence of unjustifiable professional liability suits and to suggest means of discouraging their development. Although the House disapproved the resolutions, it did act on the recommendation of the reference committe to refer them to the Conference Committee on Inter-Relations with the Judiciary and Bar for consideration of their subject matter and aims.

On 6 November 1969, a meeting was held between MSNJ's Conference Committee on Inter-Relations with the Judiciary and Bar and the Supreme Court's Committee on Relations with the Medical Profession. The following matters were considered and reacted to as indicated, on the basis of their having been referred from the House as set forth above:

1. Extension of privileged communication

doctrine to proceedings and/or records of medical review and advisory committees of hospitals and county medical societies. Also immunization from suit for the physicians serving on such committees. (Resolution #9 —Essex County)

All those present considered this desirable legislation. Judge Waugh requested that when it is introduced in the 1970 Legislature the Administrative Office of the Courts be notified and copies sent to the members of the Supreme Court Committee so that they may give it their support. . . . Legislation calculated substantially to accomplish this end has been introduced by Senator Wallwork and others. It is Senate Bill #559.

2. To require the court upon motion by either party to proceed to separate trial of an affirmative defense raising the Statute of Limitations. (Resolution #9—Essex County)

The members of the Bar indicated that this was unnecessary since such a motion is already a well-established principle of New Jersey Law.

3. To require that juries be instructed that Plaintiff has the burden of proving the defendant's negligence by a preponderance of the evidence and that injury alone does not raise either a presumption or inference of negligence. (Resolution #9—Essex County)

The members of the Bar noted that under New Jersey case law the Doctrine of Res Ipsa Loquitur is rarely invoked and then only in obvious cases where negligence is clearly established—e.g. amputation of the wrong limb. Therefore they concluded that such a requirement is unnecessary.

4. Prohibition of "contingent fees" except in cases of proven hardship. (Resolution #11— Bergen County)

Historically the contingent fee has been the poor man's key to justice, it was pointed out. This entire matter is, however, under study by the State Supreme Court.

5. To provide for abitration of malpractice claims by an impartial board of medical and legal experts. (Resolution #11—Bergen County)

It was felt by those present from the Bench and Bar that the opposition to the above would be insurmountable. All other professions and all negligence actions are subject to trial by jury. This is a fundamental right inherent in American jurisprudence. The proposal would be unacceptable to the legal profession.

6. Stipulation of limits upon amounts payable to plaintiffs in malpractice claims. (Resolution #11—Bergen County)

Currently there are no limits upon the amount of money an injured party may recover from a negligent defendant. It was felt that the application of a system of limited awards in malpractice cases would be unfair and discriminatory in view of the unlimited liability of non-physician defendants in other negligence actions. Furthermore, it was asked, upon what criteria would a stipulation of limits be based?

Approved (page 431)

Committee on Extension to Interns and Residents of Power to Sign Certain Legal Documents

(Reference Committee "E")

The 1969 House of Delegates did not approve Resolutions #15 and #23, but it did refer them to the President with the suggestion that he appoint a special committee to study the problems with which they concern themselves. Resolution #15 dealt with "Temporary Licensure for Approved Intership and Residency Programs." Resolution #23 dealt with "House Staff Prescriptions for Welfare Recipients." Subsequently, the President appointed a three-man Committee which he himself chaired and the other members of which were Doctor Emanuel M. Satulsky and Doctor Henry J. Mineur. As the result of their inquiries the following information was received:

1. The State Board of Medical Examiners reported, under date of 5 December 1969, as follows:

"Interns and Residents in an approved training program have the implied privileges that the licensed staff members enjoy. Therefore, they may write prescriptions exclusive of narcotics. There is no restriction in the Medical Practice Act."

2. The New Jersey Pharmacy Act limits pharmacists in their compounding prescriptions to filling only prescriptions issued and signed by licensed physicians. This rule does not apply in hospital pharmacies.

The Attorney General, acting in concern for certain welfare patients in Essex County, issued an informal opinion to the New Jersey Pharmacy Board which declared that prescriptions signed by interns and residents of the Martland Medical Center in Newark may be legally filled in retail pharmacies of the area. In all other areas of the State this privilege does not apply.

Approved with notations (page 433)

Standardized College Health Report Form
(Reference Committee "G")

The 1969 House (Resolution #20—Camden County) called upon MSNJ to instruct its delegates to the AMA to endorse a resolution urging that the AMA, in cooperation with the American College Health Association, set up a concise, standardized form for reporting on physical examinations administered to applicants for admission to colleges and required in support of such applications. A resolution (#79) was introduced and supported by New Jersey's delegation at the AMA meeting.

Discussion of Resolution #79 before the AMA reference committee led the reference committee in its report to declare:

Resolution #79 seeks to assure the development and implementation of a standardized college health record form that would be used generally throughout the country. Such a form has been developed by the American College Health Association in cooperation with the AMA's Liaison Representatives to ACHA. However, this form has not yet come into general use because of problems of communication and difficulties in changing record systems.

Testimony on the matter brought out two additional problems. First, although ACHA has been attempting to establish a policy in colleges and universities of not requiring a medical examination until after acceptance of a candidate, this practice is still far from being generally implemented. Second, methods should be developed to make it possible for the physician to use the standard form in lieu of individual college health forms.

In consequence of its observations, the reference committee offered the following substitute resolution for #79:

Resolved, that the AMA-ACHA Liaison Committee continue and expand its efforts to bring about (1) general utilization of the standardized health examination form available through ACHA; (2) acceptance of the policy not to require a medical examination of applicants until after admission to the institution; and (3) evolvement of a system that permits ready use by the individual physician of the standardized college health record form.

The AMA House of Delegates adopted the substitute resolution.

Approved (page 440)

Medical Advisory Committee to the Medicaid Program
(Reference Committee "E")

The Board was requested (at its meeting on 20 July 1969) to designate four nominees to serve as representatives of The Medical Society of New Jersey on the Medical Advisory Committee, which would operate in conjunction with the Medical Assistance and Health Services Act, Chapter 413, Laws of 1968.

The chief function of the Medical Advisory Committee is to advise and counsel the Medical Assistance and Health Services Division staff, which will administer the Medicaid program, concerning professionally sound recommendations on medical care furnished by physicians within the Medicaid program structure and financial and legal limitations.

The Board designated the following to serve on the Medical Advisory Committee:

Donald P. Burt, M.D., Morristown
Arthur C. Dietrick, M.D., Mount Holly
John D. Franzoni, M.D., Trenton
Samuel J. Lloyd, M.D., Trenton

Approved (page 433)

FAA Medical Examination Form
(Reference Committee "H")

In 1968 the House of Delegates adopted a resolution that called for the revision of the FAA medical examining form so as to grant immunity from suit to the examining physician. MSNJ corresponded directly with the FAA urging the foregoing change and was subsequently informed that legislation to effect that purpose was being drafted.

The 1969 House of Delegates directed that a follow-up be made to insure passage of this legislation. The matter was referred to the Council on Legislation.

At its meeting on 26 June 1969, the Council on Legislation recommended "that a letter over the signature of the President or Secretary of The Medical Society of New Jersey again be sent to the FAA urging sustained support of this legislation and that a copy of this letter be sent to the AMA with a request that it use its influence to bring the legislation to enactment." On 20 July 1969, the Board of Trustees approved the Council's recommendation.

Under date of 27 August 1969, the Society was informed by the Federal Air Surgeon that the Federal Aviation Administration is in the process of procuring evidence to show that immunity from suit would indeed override other objections to disclosure and result in improved voluntary reporting by physicians in general.

Under date of 7 August 1969, the American Medical Association indicated that it supports the position taken by MSNJ requesting legislation that would grant immunity from suit for the release of information pertaining to a pilot's physical condition.

Approved with recommendation (page 442)

Supplemental Report

The Board of Trustees held its final meeting for the fiscal year 1969-70 on Friday evening, 15 May. The following items from that meeting are directed to the attention of the House:

Special Committee to Review the Report of the AMA Committee on Planning and Development
(Reference Committee "A")

At its meeting on 18 January 1970, the Board of Trustees empowered the President to appoint a special committee to study and evaluate the Report of the AMA Committee on Planning and Development and to offer constructive recommendations to be forwarded to the American Medical Association in the name of The Medical Society of New Jersey. President Bertha subsequently appointed the following as members of the Special Committee:

Hillel M. Ben-Asher, M.D., (1st District)
James S. Todd, M.D., (2nd District)
John F. Kustrup, M.D., (3rd District)
Louis F. Albright, M.D., (4th District) . . . Chairman
Louis K. Collins, M.D., (5th District)

In mid-February sufficient copies of the Report arrived, upon request, from the AMA, to permit one copy to be sent to each of the 21 component societies, with the request that

component societies study the majority and minority reports and submit to the Special Committee any suggestions that might be developed. No suggestions were submitted.

Each member of the Special Committee was asked to prepare himself to discuss the Report in general, but also to make specific recommendations concerning the section of the Report assigned to him.

The Committee met in an extended session on Sunday, 12 April 1970, and, in consequence of the thorough preparation made by all its members, was able to make unanimous recommendations for the Society's position concerning all the recommendations contained in both the majority and minority reports.

At its meeting on 15 May, the Board received and approved the Special Committee's report of its study and recommendations. The Board directed, upon the Committee's recommendation, that specially annotated copies of the AMA Report in its entirety, indicating the positions taken by MSNJ, be prepared for the use of the Society's AMA Delegates and Alternates serving at the AMA Annual Convention in Chicago next June, at which time the Committee Report on Planning and Development is scheduled to be acted upon.

Approved (page 428)

Medicaid Peer Review Committee
(Reference Committee "E")

At the invitation of the President, Harry Kaplan, M.D., Deputy Medical Director, Division of Medical Assistance and Health Services, New Jersey Department of Institutions and Agencies, was present for a portion of the meeting of the Board of Trustees held on 19 April 1970.

The purpose of Doctor Kaplan's appearance before the Board was to obtain the Board's reaction to a proposal that there be established, in conjunction with the Medicaid Program, a Medicaid Peer Review Committee. This Committee would be composed of members of The Medical Society of New Jersey, who would be paid a per diem by the Department of Institutions and Agencies. It was proposed that the Committee be made up of nominees submitted by the Board of Trustees as representing the five judicial districts of the State. Therefore, the total Committee would consist of five members each, representing one of the judicial districts.

It would be the function of the Committee to act upon inquiries and/or complaints originating either with the administrators of the Medicaid Program or with physicians serving under the program and concerning themselves with the quality, adequacy, or excess of professional services rendered and with other related areas of concern. After some questions addressed to Doctor Kaplan, which he answered, and some limited discussion, the Board, following the withdrawal of Doctor Kaplan—upon motion by Dr. Lloyd, seconded by Doctor Kustrup, and unanimously carried —voted to approve the establishment of such a Committee. It agreed that members of the Board would submit suggestions for possible nominees to the Executive Committee in the interim between the April and May meetings of the Board.

Approved (page 433)

Journal Of Thanatology

Something new—and unique—has appeared in medical journalism, a journal of thanatology. Its articles concern inquiries into the promotion of knowledge about dying, reactions to death, the psychology of loss and grief, and the understanding and management of bereavement. For more details, write to Dr. Austin H. Kutscher, Foundation for Thanatology, 630 West 168th Street, New York 10032.

Judicial Council

John S. Madara, M.D., Chairman, Salem

(Reference Committee "A")

The Judicial Council has maintained its schedule of regular monthly meetings. From the official findings, the Council here presents a summary of its operations and those of county judicial committees for the period from 1 April 1969 through 31 March 1970.

By Judicial Committees

Complaints reported as disposed of 74

Alleging:

Dissatisfaction concerning fees	48
Unethical conduct	4
Dissatisfaction with services rendered	9
Unprofessional conduct	13

By the Judicial Council

Meetings held	7
Official communications acted upon	10
Appeal hearings requested	6
Appeal hearings granted	3
Formal opinions rendered	5

(1) The ethical acceptability of a physician's referring a patient to a lay hypnotist to work under his direction

(2) The ethical acceptability of applying a stamp to a bill giving a deduction of 25% if paid within 90 days

(3) The ethicality of advertising by lay clinical laboratories in AMA publications

(4) The ethical acceptability of a letter addressed to fellow physicians soliciting cytology and biopsy materials for study and report on a fee for service basis

(5) The ethicality of certain orthopedic surgeons signing their names on casts

The foregoing opinions are presented in full as an appendix to this report.

Regulations

The Council would at this time like to point out to the chairmen of the judicial committees of the component societies that there has been, in the last year, an inadequacy of cooperation with the Judicial Council on the part of the committees. The main problem is failure to file, or lateness in filing, the required report forms to inform the Council of the existence and status of complaints before county judicial committees. Many times the Council has received requests for appeal hearings concerning complaints disposed of, but not reported by, county judicial committees. The Council urges that each county committee strive to improve its procedure in this regard. Therefore, the committees are again reminded to follow the directions contained and the procedural steps outlined in the *Rules and Regulations for the Processing of Grievances and Complaints.* Only by means of a full understanding and observance of the "Regulations" can the judicial committees together with the Judicial Council succeed in functioning at the level of adequacy intended by MSNJ's House of Delegates.

Opinion #1

Ethical Acceptability of a Physician's Referring a Patient to a Lay Hypnotist to Work Under His Direction

The Council's attention was directed to a request for an opinion from the Chairman of the Judicial Committee of a component society as to whether it is ethical for a physician to refer a patient to a lay hypnotist to work under his direction.

It was the Council's unanimous opinion that under the Medical Practice Act of New Jersey it is lawful for a physician to authorize that procedures be carried out on his patient, at his specific direction, only by "a podiatrist, professional nurse, registered physical therapist, or masseur." To use a hypnotist for such procedures, therefore, would be unlawful. Knowingly to violate the law would contravene Principle #4 of the *AMA Principles of Medical Ethics,* the relevant section of which

reads: ". . . Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. . ."

Opinion #2

Ethical Acceptability of Applying a Stamp to a Bill Giving a Deduction of 25 Per Cent if Paid Within 90 Days

This request for an opinion from the Chairman of the Judicial Committee of a component society was directed to the Council's attention. In considering the question as to whether it was ethical to apply a stamp to a bill giving a deduction of 25 per cent if paid within 90 days, the Council rendered the following opinion:

There is no specific principle of the *Principles of Medical Ethics of the AMA* that the practice violates. However, it is definitely in poor taste, and though accepted as a business practice, is not consonant with the dignity of the profession of medicine and should be discouraged as in violation of the standards of professional conduct.

Opinion #3

Ethicality of Advertising by Lay Clinical Laboratories in AMA Publications

The Council considered in depth Resolutions #18 and #26 of the 1969 House of Delegates, which although not adopted by the House, were referred by it to the Council for consideration and opinion relative to the ethical points involved. Both of these Resolutions were titled — "Solicitation and Commercial Advertising of a Medical Specialty By Lay Corporations in AMA Publications." They are substantially the same.

The Council would initially like to point out that the AMA *Principles of Medical Ethics* are binding upon physician-members of the American Medical Association and of such other medical associations and societies as have officially adopted them, as has The Medical Society of New Jersey. They are not binding on other agencies and/or individuals.

In the March 30, 1957 issue of *JAMA*, the following opinion of the AMA Judicial Council was published:

Unethical Advertising: The Principles of Medical Ethics do not proscribe advertising as such; they proscribe the solicitation of patients. Advertising, in its broad sense, means the act of making information, fact, or intention known to the public. Solicitation as used in the Principles means the attempt to obtain patients by persuasion or influence. Advertising as distinguished from solicitation is not in itself unethical . . .

. . . The particular use to be made of any ethical advertising medium and the extent of that use are, however, matters to be determined according to local ideals. What constitutes an excess, what is not in keeping with the ideals of medicine, what transcends advertising and becomes solicitation are questions of fact. The application of this principle is to be made locally.

On September 28, 1958 the MSNJ Council, in Opinion #12, considered the ethicality of the following two classified advertisements appearing in *The Journal* of The Medical Society of New Jersey:

"Radiologist will interpret films taken in practitioners' offices. Reports telephoned immediately. Developing service, technical assistance and pickup messenger service available. Write Box MO, c/o The Journal."

"Fungus Diagnostic Services—Prompt determination of fungus disease from skin scrapings, blister tops, hair and nail clippings. Inquiries invited. 7 Watchung Ave., Plainfield, N. J."

The Judicial Council concluded:

"In these instances there is no solicitation of the public involved, since the advertisements are addressed only to fellow-physicians, appearing as they do, in a medium intended exclusively for members of The Medical Society of New Jersey.

"Therefore, in light of the foregoing, it is the opinion of the Judicial Council of The Medical Society of New Jersey that the practice as reflected in the advertisements submitted for study does not violate the *Principles of Medical Ethics* of the AMA, and in consequence, is not unethical."

In 1965, in Opinion #51, a matter of a similar nature was before this Judicial Council concerning the ethicality of a proposed program for soliciting members of The Medical Society of New Jersey for the reading of Papanicolaou smears. The Council was unanimous in its opinion that:

". . . in this instance, since the physician is announcing the availability of his services to other physicians, there is no solicitation of patients involved. . ."

Resolutions #18 and #26 of the 1969 House of Delegates of The Medical Society of New Jersey are concerned with advertisements of lay corporations. The Council studied the representative advertisement before it in great detail and noted that (1) the copy is addressed exclusively to practicing physicians; (2) specimens are to be sent by the physician to the laboratory; (3) reports are returned only to the physician who has submitted them; and (4) no specimens will be accepted directly from patients and no reports will be made to patients.

In light of the foregoing, it is the opinion of the Council that there is no solicitation of patients nor anything unethical in such an advertisement.

The Judicial Council is informed that the present policy of *JAMA* opens its advertising columns to commercial laboratories under corporate names but refuses to publish like advertisements submitted by named physician laboratory directors. The Judicial Council regards this policy as discriminatory and is of the opinion that it should be reviewed and impartially and uniformly adjusted in the interest of equity.

Opinion #4

Ethical Acceptability of a Letter Addressed to Fellow Physicians Soliciting Cytology and Biopsy Materials for Study and Report on a Fee for Service Basis

The Council considered a letter addressed to a member of a component medical society in South Jersey by a member of a component society in North Jersey.

The letter reads as follows (with editorial changes to preserve confidentiality):

Dear Doctor:

Because many physicians in (your) county are experiencing increasing difficulty obtaining adequate coverage for the cytology and biopsies from their practice, and because most physicians will separate this anatomical pathology from their routine lab work, I am calling to your attention our unique laboratory.

(My associate) and I are certified pathologists and devote our entire private practice to our laboratory for cytology and biopsies. This offers many advantages to you and your patients.

We supply all of the necessary materials including: slides, forms, cardboard mailers, formalin-filled biopsy tubes, postage-paid envelopes, etc.

All cytology is examined the day it is received, hence, you can have 3-day service.

A copy of our cytology report-form is enclosed and you can see that every case is reported completely in regard to: abnormal cells, trichomonas, monilia, non-specific infections, and strength of estrogen and progesterone.

Billing is to the physician on a fee-for-service basis.

To request our fee schedule, or any other information about our laboratory, call us or use the enclosed envelope.

Even if you do not wish to use the services of our laboratory at this time, I would like to hear from you regarding any suggestions for the improvement of cytology and biopsy services.

The Judicial Council of the American Medical Association presented the following opinion to the AMA House of Delegates at the 1965 Clinical Convention:

1. The practice of pathology is an integral part of the practice of medicine.
2. All physicians should bill their patients directly, and
3. In exceptional cases, when it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the charge for laboratory services, including the name of the physician director of the laboratory, as well as the charges for his own professional services.

The Judicial Council of The Medical Society of New Jersey is of the opinion that the proposal contained in the subject letter to bill the physician on a fee-for-service basis for the laboratory work done contravenes section 2 of the above-quoted AMA Judicial Council opinion. The pathologist should bill the patient, and the referring physician should inform his patient that such bill for the pathologist's professional services is to be expected. . . . Disregard of this dictum regarding direct billing is unethical, and the subject letter is declared unethical on that basis.

The accuracy of the statement contained in paragraph one of the letter has been challenged. If this charge is true, an ethical criterion, of a general not a medical character, is being disregarded and, therefore, the state-

ment and the paragraph should be either deleted or revised.

The Judicial Council of The Medical Society of New Jersey wishes, at this time, to call attention to a related opinion of the Judicial Council of the American Medical Association:

> The particular use to be made of any medium of communication (found ethically acceptable) and the extent of that use are, however, matters to be determined according to local ideals. . . . The propriety of the advertising practices of medical laboratories should be determined at the local level . . .
>
> Adopted at 1962 Clinical Convention

On the basis of the foregoing, if the subject letter is revised to eliminate its present unethical element of a fee-for-service billing to the referring physician, it should then in its revised form be cleared with that component society of The Medical Society of New Jersey in which the issuing physician holds membership.

Opinion #5

Ethicality of Certain Orthopedic Surgeons' Signing Their Names on Casts

The aforementioned request for an opinion from a member of a component medical society was considered next by the Council.

After a thorough review and discussion of this request for an opinion, the Council agreed unanimously that medical ethics frown upon any display of a physician's name which has the effect of self-promotion or self-laudation. However, if the county society of which a physician is a member agrees that the signing of casts is permissible for practical purposes of service to the patients' interests, certainly full names should never be used; initials should suffice and should be so placed as to be inconspicuous except to someone specifically looking for them. The acceptable usage should be stipulated by the judicial committee of the component society.

The Council directed that a letter setting forth the foregoing findings be sent to the member-physician who requested this opinion, with a copy to the President of his component society.

Approved (page 428)

1969 TRANSACTIONS

At its first session on Saturday, 16 May 1970, the House of Delegates approved the Transactions of the 1969 House of Delegates as published in the July 1969 issue of THE JOURNAL and distributed to the membership.

Executive Director

Richard I. Nevin, Trenton

(Reference Committee "A")

It is only natural that after the long travail of winter we should all find ourselves weary at the approach of spring. But the administrative year through which we have just passed added burdens of its own so taxing that all but the most stalwart of us must feel debilitated almost to the point of exhaustion.

In the two decades that I have served The Medical Society of New Jersey and enjoyed the privilege of working with its officers and members, I can recall no year that made more exacting and unremitting demands than that which now draws to its close. Nor can I recall any year in which a more wholesome sense of responsibility and of duty prevailed. For that circumstance I pay grateful tribute to the inspirational efforts of our President, Dr. Nicholas A. Bertha, and of his colleagues of the Board of Trustees and of the Councils and Committees, and to the faithful, generous, and able members of our Staff. One and all they proved that "sweet are the uses of adversity," that difficulties faced and dealt with bring out the best in people, and that nothing is more instinct with the power to survive and overcome than an indomitable spirit and an unflagging faith in the worth of one's goals.

The basic task of Medicine, to develop and use for the benefit of people in every walk of life every possible extension and refinement of service, is itself a staggering obligation. But when you add to that the further obligations of serving on demand more people, in exacting fashion, than manpower limitations make possible; of fulfilling the thoughtless, sweeping promises which others irresponsibly make; of producing, unfailingly, results of a character so almost miraculous as to transcend the limits of merely human capabilities; of working without consideration of the need for rest and relaxation; of being denied the right to expect increased income for added expenditure of effort; of being condemned for attempting to adapt charges for professional services to the soaring levels of inflation . . . then the tasks of Medicine become formidable indeed.

To these tasks and to the myriad problems which apparently they spontaneously generate we have vigorously applied ourselves through the year, with what all-embracing concern the voluminous bulk of the reports being submitted to the House and the monthly minutes of the Board of Trustees give eloquent testimony.

Although the reports of all Councils and Committees merit appreciation and careful study, I particularly call attention to the reports this year of the Council on Legislation, the Council on Medical Services, and the Committee on Medical Defense and Insurance, as representing areas of concern of vital importance to all our members in these times, and as reflecting an assiduity and completeness of service that should be a source of general satisfaction.

Our experience in New Jersey with both the Medicare and Medicaid Programs, while certainly not free of elements of dissent and dissatisfaction, has been marked by a bilateral attitude of reasonableness and of willingness to work out difficulties in a spirit of amity and cooperation. The frequency of conferences and negotiating sessions and the results so far attained attest to this circumstance.

Common concerns have kept us in close contact with related professional groups, such as the New Jersey Hospital Association, the Nurses Association, the Pharmaceutical Association, the Health Insurance Council, the Medical Assistants' Association, and the Bench and Bar. Our Conference Committee with the Judiciary and the Bar agree that never have we had better rapport with the Supreme Court's Committee on Relations

with the Medical Profession than this year we have enjoyed. The fact that the New Jersey Hospital Association has extended to me the privilege of participating in the meetings of its Board of Trustees is, I think, an indication of good will that merits special remark and appreciation.

My personal role in the conduct of the Society's business has involved me in all that has transpired, both in dealing with the individual needs of our members in coordinating and supervising our total organizational operation and interrelationships. I find from my diary that I took part in 142 meetings and conferences of all kinds, visited 11 component societies, made two journeys out of State to AMA meetings in New York and Denver, and made 13 speech presentations.

There is danger in these troubled times, when members of the medical profession are exposed to blame for much for which they are not responsible and are not in position to control, and when standards and values are so inconstant and apparently confused, that we might succumb to discouragement and, in dejection of spirit, lose the will to fight on. Nothing could be more perilous for personal happiness or professional distinction. We should take heart from the fact that if society is to survive it must re-establish the sovereign importance of human freedom, dignity, and decency, maintained and fostered under a system that exalts justice and truth.

If Medicine presently suffers under some diminution of its former prestige and esteem because of radical changes that are taking place, let us be true to the constancies of worth that we firmly know, as persons and as physicians. Strong in that knowledge and with faith in ourselves and in our convictions let us work on, fight on; and let us say to the graceless and arraigning world

"My loss may shine yet goodlier than your gain
When Time and God give judgment."

Approved (page 428)

Annual Meeting

James A. Rogers, M.D., Chairman, Paterson
(Reference Committee "H")

The committee met twice in June, once in September, and again in January to formulate plans for the 204th annual meeting in accordance with directives of the 1969 House of Delegates and of the Board of Trustees.

The final meeting of the 1969-70 Board of Trustees will be held at Haddon Hall at 4:00 p.m., Friday afternoon, 15 May; and the reorganization meeting will be held at 8:30 a.m., on Wednesday, 20 May.

An additional room adjoining the Officers' Hospitality Suite has again been reserved for the comfort of invited guests and for the private discussion of business of the annual meeting. A detailed outline of the duties, responsibilities, and time assignments will be made available in advance to the co-hosts of the Hospitality Suite.

The 1970 House of Delegates will meet on Saturday (16 May), Sunday (17 May), and

Tuesday (19 May). Official guests will be called upon to make their presentations at the first session only. Also during the first session, the Deans of New Jersey's two medical schools will be called upon to receive their AMA-ERF checks and to present reports on the status of their medical schools and their plans for the future. A General Session on the Medicaid Program will feature representative-speakers from Prudential, Institutions and Agencies, and Health, Education and Welfare. An Open Discussion on Medical-Surgical Plan of New Jersey is also scheduled for Saturday afternoon.

The second (election) session of the House will be followed by the farewell address of the outgoing President and the inauguration of the incoming President. The third session of the 1970 House will begin promptly at 9:00 a.m. on Tuesday and, with the exception of the presentation of Scientific Exhibit Awards, will be limited exclusively to the business of the House.

The Nominating Committee will meet at 4:30 p.m. on Saturday; and reference committees are scheduled to meet at 11:00 a.m. on Sunday. Reference committee reports will be made available in advance of distribution to the House to members of the reference committees and to *one* officially designated representative of each component society.

Registration will open in the Exhibit Hall at 10:00 a.m. on Saturday. The thirteenth Golden Merit Award Ceremony will precede the first session of the House on Saturday.

In order to avoid conflict with the sessions of the House, the scientific sessions are scheduled for Sunday morning and early afternoon, and for all day Monday. The 1970 Motion Picture Theatre will again be sponsored by Ciba Pharmaceutical Company, and an outstanding selection of timely films will be shown. In addition to MSNJ's scientific sessions, the New Jersey College of Medicine and Dentistry will present a special program on Drug Abuse.

A program of special entertainment has been arranged for Saturday evening at 9:00 p.m. in the Viking Room. Talented members of MSNJ and the Woman's Auxiliary will perform for the enjoyment of their fellow delegates and members.

The Inaugural Reception is scheduled for Sunday evening. All registered members, official guests, and their wives are invited to attend; admission will be by badge. The Reception-Buffet Dinner honoring technical exhibitors will be held at 8:00 p.m. on Sunday evening. The invitation list will include technical exhibitors, Trustees, and Officers. Tickets will be on sale at the Registration Desk for all others wishing to attend. The Annual Dinner-Dance, honoring the President, will be held on Monday evening.

The Advance Program was mailed in early February to the membership, invited speakers and guests, non-member exhibitors, and to editors of journals of nearby state medical societies. The April issue of *The Journal* carried the detailed day-by-day outline of the annual meeting, including abstracts of the scientific session presentations. The final program will be distributed to all who register at the convention.

All exhibits will be set up in the Exhibit Hall, and exhibit hours will be from 10:00 a.m. to 5:00 p.m. on Sunday, from 9:00 a.m. to 5:00 p.m. on Monday, and from 9:00 a.m. to 3:00 p.m. on Tuesday. Thirty-four scientific, 13 informational, and 45 technical exhibits will be shown. The Coffee Lounge will again be sponsored by the Prudential Insurance Company of America, and the American Association of Medical Assistants, State of New Jersey, will be in charge of the Message Center. Both of these services will be available in the Exhibit Hall.

Through the Deans of New Jersey's two medical schools, invitations were sent to medical students asking them to present scientific exhibits at the 1970 annual meeting. Through the Committee on Medical Education special invitations were extended to medical students at Rutgers Medical School and the New Jersey College of Medicine to attend the scientific

sessions and to visit the exhibits. Distinctive ribbon badges will be available for all medical students who register at the annual meeting.

Loss of revenue in recent years has been progressively due to reduction in the number of technical exhibits. To offset this loss the Board approved acceptance of contributions from pharmaceutical houses in lieu of exhibiting, provided that the funds thus realized were earmarked exclusively for educational purposes.

In September, in conference with representatives of the Academy of Medicine of New Jersey, it was agreed that to stimulate better attendance at scientific sessions, with the cooperation of the New Jersey Specialty Societies, it would be desirable to procure more outstanding speakers, with increased cost for travel and honoraria.

The Board approved the following related recommendations:

1. That announcement be made that the Society is taking steps to increase the quality, scope, and number of its scientific sessions and programs;

2. That in support of this educational effort an annual list of "Official patrons of the Educational Programs of The Medical Society of New Jersey" be compiled. Place on such list would be given to all contributors of $100 or more. Invitations would be extended to pharmaceutical houses, book publishing companies, instrument and supply houses, investment houses, and other approved agencies that offer services or products to the medical profession and its practitioners.

Letters of invitation to participate in this educational endeavor were mailed late in February. As of this printing, approximately $1,000 has been realized.

In January an informal dinner-meeting was held with representatives of New Jersey Specialty Societies and the Academy of Medicine. The primary purpose of this meeting was to implement the action of the 1969 House of Delegates, including the recommendation of Reference Committee "H" . . . to encourage specialty groups throughout the State to combine all their separate annual meetings at one time under the aegis of the Scientific Sessions of MSNJ and for each specialty to formulate its program to stimulate maximum attendance by its membership . . . Seventeen of the 21 specialty societies were represented at the meeting and the consensus of the conferees supported the proposal of joint scientific sessions in 1971 as feasible and desirable. Following the 1970 annual meeting, request will be made of each specialty society for an official indication as to whether or not it approves the proposal and is willing to participate.

The committee again wishes to stress the importance of all members visiting the exhibits. The monies derived from the sale of technical exhibit booth space is the only sure source of revenue to offset annual meeting expenses. Everyone is urged to support our exhibitors and to visit the exhibits.

The House of Delegates has already approved the following annual meeting dates, which have been confirmed with Haddon Hall:

205th annual meeting
—Saturday-Tuesday, May 15-18, 1971
206th annual meeting
—Saturday-Tuesday, May 13-16, 1972
207th annual meeting
—Saturday-Tuesday, May 12-15, 1973

Recommendation

That the 208th annual meeting of The Medical Society of New Jersey be held in Haddon Hall, Atlantic City, Saturday-Tuesday, May 11-14, 1974.

Approved with notations (page 442)

A New Outlook In Alcoholism

Speaking to the Senate Subcommittee on Alcoholism recently, Marvin A. Block, M.D., said that, "Apart from research, the crying need is for community facilities to treat and care for the alcoholic patient, who is entitled to the same rights and opportunities for treatment accorded other sick people."

Scientific Exhibits*

Sidney S. Girsh, M.D., Chairman, Atlantic City

(Reference Committee "H")

The Subcommittee on Scientific Exhibits met twice during the year. The exhibits submitted were categorized as medical, surgical, or informational. Motion pictures were selected for the theater. In an effort to increase attendance at the exhibits, the committee suggested that, at each Scientific Section Meeting, the physician-in-charge be requested to urge all in attendance to visit the exhibits at the conclusion of the session. The committee also suggested that a form be distributed to each technical, scientific, and informational exhibit booth stressing the importance of having someone in attendance at the booth, particularly at the time of 11:45 a.m. and 4:15 p.m.

The awards for the exhibits will be as follows:

(1) Three plaques awarded for presentation to New Jersey exhibitors (first, second and third place).

(2) Two plaques awarded to out-of-state exhibits (first and second place).

(3) There will also be five honorable mention certificates for New Jersey exhibitors and two honorable mention certificates for out-of-state exhibitors.

(4) If exhibits are presented by students from New Jersey's two medical schools, the outstanding exhibit from each medical school will be awarded a certificate of merit, plus a check in the amount of $50.

It was also recommended that the awards for the most outstanding scientific exhibits be made at the third session at the House of Delegates, on Tuesday, May 19, 1970.

The Subcommittee on Scientific Exhibits recommended certain awards, and the Board has amended and approved the recommendation. The awards which were amended and approved were listed above.

Aproved (page 442)

Scientific Program*

Robert E. Verdon, M.D., Chairman, Cliffside Park

(Reference Committee "H")

Under the chairmanship of Robert E. Verdon, M.D., the Officers of the Scientific Sections met three times with the Committee on Annual Meeting. Representatives of the New Jersey Specialty Societies were present at the September meeting, and again at a special dinner-meeting held in Princeton in January.

All of the twenty-one MSNJ Scientific Sections will meet in 1970—in accordance with the following schedule which was set up at the September meeting:

Sunday morning, 17 May 1970

Session on Obstetrics and Gynecology
Session on Rheumatism

Sunday afternoon, 17 May 1970

Joint Session on Anesthesiology, Otolaryngology
Session on Cardiovascular Diseases
Joint Session on Dermatology, Metabolism
Session on Psychiatry and Neurology

Monday morning, 18 May 1970

Joint Session on Allergy, General Practice, Pediatrics
Joint Session on Chest Diseases, Surgery
Joint Session on Clinical Pathology, Gastroenterology and Proctology
Session on Orthopedic Surgery, co-sponsored by the New Jersey Orthopaedic Society
Joint Session on Radiology, Urology

Monday afternoon, 18 May 1970

Session on Medicine
Session on Ophthalmology
Session on Plastic and Reconstructive Surgery

*Sub-Committee of Annual Meeting Committee

In addition to the programs to be presented by MSNJ's Scientific Sections, a Special Scientific Session on Drug Abuse, sponsored by the New Jersey College of Medicine and Dentistry, will be held at 10:00 a.m. on Sunday morning, 17 May.

A total of sixty-four outstanding member- and guest-speakers will participate in the 1970 Scientific Programs.

It should be noted that the 1970 Scientific Programs have been arranged and scheduled so as not to conflict with the business sessions of the House of Delegates. Therefore, it is hoped that attendance at the 1970 sessions will be greatly improved over past years.

Approved with notations (poge 442)

Credentials

Charles L. Cunniff, M.D., Chairman, Jersey City

(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the committee's activities during the period 1 April 1969 to 31 March 1970.

The Committee extends appreciation to the secretaries of component societies, and to those who assist them, for their cooperation in processing membership applications. It would be especially helpful to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials.

	Associate	Active by Advancement	Active	Total
Received	302	307	60	669
Reviewed and found:				
Satisfactory	270	277	52	599
Unsatisfactory	0	0	0	0
Pending	32	30	8	70
Total	302*	307	60	669

* 82 Associates are Non Citizens.

Approved (poge 428)

Honorary Membership

Ralph M. L. Buchanan, M.D.,Chairman, Phillipsburg

(Reference Committee "H")

No nominations were submitted this year to the Committee. Consequently, no meetings were held during this administrative year.

Approved (page 442)

Finance and Budget

Thomas C. DeCecio, M.D., Chairman, Cliffside Park

(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

The Journal

The anticipated *Journal* Deficit has increased, for the second consecutive year. This can be attributed to several factors: (1) reduced volume of advertising supplied by SMJAB, while local advertising income has remained stable; (2) the effects of the new rate structure reflecting 10% increase for full and one-half page advertisements, although effective 1 January 1970, has not achieved full impact on *Journal* income; (3) and the effect of an 8% production cost increase as of April 1969. The anticipated increase for 1970 is not known at this time. However, this trend is consistent within the printing industry, and it is felt that the printer has rendered another satisfactory year in printing *The Journal.*

The anticipated deficit for publication of *The Journal,* Journal salaries and salary taxes (including those of the editor and assistant editor), Journal office expenses and travel, editor's insurance, and other Journal expenses will be charged off to the unexpended balance in the 1969-70 budget accounts at the end of this fiscal year. A net surplus will still result in the 1969-70 total budget.

Your committee has approved, with the concurrence of the Board of Trustees for the second consecutive year, the continuation of the Journal Deficit Reserve Account established to offset any future deficit when there may not be sufficient unexpended surplus to absorb a *Journal* Deficit.

1971 Assessment

The computation of cash surplus at the close of the current fiscal year is estimated at $234,758.97 — 56.5% above the $150,000.00 sum which has been indicated as the desired minimal surplus.

In accordance with Chapter X of the Bylaws, the dues year is 1 January to 31 December, and the fiscal year is 1 June to 31 May. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the 1970 and 1971 per capita assessment to the 1970-71 fiscal year on the basis of 7/12 of the 1970 assessment for the new fiscal year soon to commence (1 June 1970) and 5/12 of the 1971 assessment for the latter part of that fiscal year starting 1 January 1971.

The following is the Computation of Cash Surplus and the Determination of the 1971 Assessment:

Proposed budget for 1970-71	$407,067.00
7/12 of 1970 assessment applicable to 1970-71 budget	213,066.20
Amount to be raised by 5/12 of 1971 assessment	$194,000.80
$70.55 × 6,600 members paid = $465,630.00 × 5/12	$194,012.50
Amount to be raised with surplus over $150,000.00 applied to budget excess at 5/31/70, estimated	$ 84,758.97
Amount needed to reduce the per capita assessment from $70.55 to $55.00	42,750.80
Remainder of surplus in excess of $150.000.00	$ 42,008.17
Add the required surplus	150,000.00
Estimated adjusted cash surplus at 5/31/70	$192,008.17
$55.00 × 6,600 members paid = $363,000.00 × 5/12	$151,250.00
plus the amount raised from surplus	42,750.80
Amount to be raised to meet 5/12 requirement	$194,000.80

For each $1,000.00 increase in the proposed budget add 36¢ to assessment. For each $1000.00 decrease in the proposed budget, subtract 36¢ from assessment.

1970-71 Budget

The proposed budget for 1970-71 totals $407,067.00. It is the opinion of the committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, the committee is listing explanatory footnotes on accounts which show a marked difference between current and proposed budgets.

Recommendations

1) That the budget for 1970-71 be adopted in the total sum of $407,067.

Approved with recommendations (page 430)

2) That the 1971 assessment be adopted at $55.00 per capita, with no provision for a contribution to AMA-ERF. The dues assessment will cover a budget allocation for the second consecutive year, to the Academy of Medicine of New Jersey which eliminates the need for a special assessment therefor.

Approved (page 430)

ACCOUNT	CURRENT 1969-70 BUDGET	FOOT-NOTES	PROPOSED 1970-71 BUDGET
A— 1—Executive Salaries	$ 61,270.40	(1)	$ 66,710.40
A— 2—General Staff Salaries	103,919.97	(1)	113,277.24
A— 3—General Exec. Office Expenses	16,000.00	(2)	17,000.00
A— 4—Executive Travel	3,000.00		3,200.00
A— 5—House Maintenance	19,000.00		19,000.00
A— 6—Treasurer	5,800.00	(3)	6,600.00
A— 7—Finance & Budget	75.00		75.00
A— 8—Secretary	450.00		400.00
A— 9—Salary Taxes	7,290.63	(4)	8,749.36
A—10—Insurance	8,810.00	(5)	10,200.00
A—11—House Reserve	6,600.00		6,500.00
A—12—MSNJ Pension Plan	——	(6)	1,400.00
C— 2—Legislation	8,800.00	(7)	8,400.00
C— 3—Public Health	2,650.00		2,600.00
C— 4—Public Relations	6,800.00		6,800.00
C— 5—Medical Services	700.00		700.00
C— 6—Mental Health	1,450.00		1,400.00
D— 1—President-Pres. Officers	14,960.00		15,000.00
D— 2—AMA Delegates	8,400.00	(8)	12,650.00
D— 3—Woman's Auxiliary	3,175.00	(9)	4,805.00
D— 4—Medical Education	35,150.00		35,200.00
D— 5—Conference Groups	500.00		500.00
D— 6—Membership Directory	15,000.00	(10)	14,000.00
D— 7—Emergency Medical Care	325.00		300.00
D— 8—Credentials & Membership	350.00	(11)	600.00
D— 9—Archives & History	100.00		100.00
D—10—Project Hope—Vietnam	6,000.00		6,000.00
D—11—Med. Def. & Insurance	500.00		500.00
E— 1—Board of Trustees	6,150.00		6,100.00
E— 2—Contingent	10,000.00		10,000.00
E— 3—Judicial Council	550.00		500.00
E— 4—Legal	6,300.00	(12)	7,300.00
E— 5—Health Facilities Planning Council	5,000.00		5,000.00
E— 6—Medical Student Loan Fund	5,000.00	(13)	12,000.00
E— 7—Authorized Reimbursement for Representatives to Meetings	3,500.00		3,500.00
TOTALS	$373,576.00		$407,067.00

Approved (page 333)

FOOTNOTES FOR BUDGET

(1) — Increase due to granted increments to both executive and general personnel.
(2) — Increase due to higher office service expenses.
(3) — Increase due to the inclusion in this account of the Annual Commission cost on the Investment Portfolio.
(4) — Increase due to higher salary taxes resulting from increased staff salaries.
(5) —Increase due to higher premiums in Blue Cross Hospital Service Plan coverage.
(6) — Establishment of a new account to reflect the annual administration cost of the New Employee Pension Plan effective 1 June 1970.
(7) — Decrease due to lower anticipated expenses chargeable to this account.
(8) — Increase due to the Board of Trustees (15 March 1970) decision to send not only seven regular delegates but also six alternate delegates to both the AMA Annual Meeting in Chicago and the Clinical Meeting in Boston.
(9) — Increase due to AMA Annual Woman's Auxiliary meeting in Chicago.
(10) — Decrease due to higher sales on the 1968-69 *Membership Directory*.
(11) — Increase due to anticipated reordering of membership application forms.
(12) — Increase due to increment granted Legal Counsel.
(13) — Increased to accommodate an anticipated shortage of funds available to qualified senior and junior medical students.

Medical Defense and Insurance

William J. D'Elia, M.D., Chairman, Neptune City

(Reference Committee "C")

Accident and Health Insurance

The Society's accident and health insurance program has just completed its 39th year of service to our members. This comprehensive disability income program affords a total monthly benefit of up to $2200 a month during total disability due to injury or sickness. The program consists of two parts: the Basic-Extended Plan and the Long Term Plan. The plans differ primarily in the length of time benefits are payable. For an accident disability the Basic plan pays up to five years; the Basic-Extended plan up to lifetime; and the Long Term plan up to lifetime. For a sickness disability, the Basic plan pays up to two years; the Basic-Extended plan up to seven years; and the Long Term plan up to age 65.

Basic-Extended Plan

This year the Board of Trustees approved the consolidation of the entire Basic-Extended program into the coverage provided by the Nationwide Mutual Insurance Company. The Basic disability plan provides as much as $1200 monthly benefit with the Nationwide Mutual Insurance Company. Benefits are payable from the first day of accident total disability for as long as five years and from the eighth day of sickness total disability for as long as two years. The plan also pays, at half the monthly benefit rate, from the first day of accident partial disability for as long as six months. The plan also includes accidental death and dismemberment benefits. By adding the Extended plan, accident total disability benefits may be extended to lifetime, and sickness total disability benefits may be extended for an additional five years, or a total of seven years altogether. There are 6,386 Basic policies in effect covering our members, with some members having two basic policies.

Long-Term Professional Income Protection Plan

This plan, through the Nationwide Mutual Insurance Company, provides up to $1000 monthly benefit in addition to the benefits

provided under the Basic-Extended plan. Benefits are payable for lifetime for accident total disability and to age 65 for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall into place, such as proceeds of Keogh programs, annuities, life insurance settlement options, and social security. The plan also affords six months of partial disability at half the monthly benefit rate. Benefits may begin from the 15th, 31st, 61st or 91st day of disability, with appropriate reductions in premium. Currently 617 members participate in this program, which began in 1967.

It is possible for a member to have the various disability plans in almost any combination of monthly benefits and plans to fit personal requirements. The ideal goal for most physicians is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary, inasmuch as all benefits are tax-free for Federal Income Tax purposes.

Members who apply for the Basic-Extended Plan within their new member periods are issued coverage, within certain limits, without regard to medical history. All of our accident and health policies now have the guaranteed Conversion Provision Rider. Briefly, this rider provides that if Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society, the company is committed to issue a guaranteed renewable policy for the same benefits as those provided each insured member under the Society's program.

Major Expense Plan

Our Major Expense Plan provides up to $15,000 of benefit paying 80% of covered expenses in excess of a $500 deductible. 2714 of our members plus dependents are participating in this program at the present time.

Hospital-Money Plan

Last year the Society approved the addition of the Hospital-Money Plan to its insurance program. The Hospital-Money Policy provides $20, $30, or $40 a day for each day of hospital confinement up to a maximum of 365 days for any one confinement. It can cover the member, spouse, and dependent children. A non-selective charter enrollment has already been conducted. The enrollment quota has been met and all eligible members and eligible dependents under age 65 have been assured at least a $20 daily policy without regard to medical history. New members are now able to obtain this program non-selectively as part of their new member privilege.

Life Insurance—Nationwide Life Insurance Company

Our life insurance program is being expanded to include not only the member but also his spouse, dependent children (between the ages of 15 and 21, or up to age 26 if college students) and employees. An important feature of this expansion is that each person will have his own Five Year Renewable and Convertible Term Policy, and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or an employee. This added feature enables the life insurance program to serve many more needs of our members, especially those who wish to provide benefit programs for their employees.

The life program provides each insured person a Five Year Renewable and Convertible Term Policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program provides up to $100,000 of coverage for members and up to $50,000 of coverage for spouse, dependent children, and employees. All coverage is issued in the form of convenient units of $10,000, with waiver of premium and double indemnity for accidental death included without premium charge.

Since inception of the program there have been 178 death claims in which a total of $1,792,000 was paid out. Through the large volume of insurance and strong participation of our members in this program we are able

to have non-cancellable term life insurance at a very low cost.

At the present time, our members are covered by $25,540,000 of insurance currently in force.

Six Point High-Limit Accident Insurance Plan

Our Six Point High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company provides up to $200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance, and even a total disability feature at less than the usual cost of the accidental death benefit alone. Special spouse coverage is available under this policy at very low cost. 715 of our members participate in this program.

Professional Corporations

The administrator advises us that all these programs are adaptable for use in Professional Corporations with the necessary assignment forms available on request.

Recommendation

That the E. and W. Blanksteen Agency be continued as the official broker for MSNJ's Accident and Health, Major Expense, Hospital Money, Life, and High-Limit Accident Programs.

Approved (page 431)

Professional Liability

Your committee has given considerable time to our professional liability program, its problems, and increased costs. The problems and increased costs are not local in nature.

The *Membership Newsletter,* number 201 of March 1970, contained information furnished by our committee. Any member reading that report must be aware of the critical position nationally of professional liability insurance.

Nationwide, the market for medical professional liability insurance is poor. It has been reported repeatedly that loss experience for this coverage has been getting worse, especially during the past few years. Many physicians, and in some states most physicians, at times have been unable to get any insurance. Others could purchase only inadequate coverage or inadequate limits of liability. California has been a historical problem area, but in the past few years the problem has spread into virtually every state.

When we refer to the situation in California and other states, some members refuse to accept the comparison. Mr. Britton stated that he has seen the situation deteriorating over the past ten years but more rapidly in the past two years. The $20,000 claim now is worth three to five times as much and the judgment could be ten to twenty times as great.

In 1969, the two companies writing most of the professional liability insurance in Pennsylvania refused to renew most of their policies and canceled some. Many physicians had to seek coverage from Lloyds of London. When the rates were substantially increased, the second largest writer, covering about 35 per cent of the Pennsylvania physicians, resumed its underwriting but only for those physicians "who met its normal underwriting standards." This could mean those who had no previous claims or were not in a hazardous practice or who did not exceed a selected age. Many Pennsylvania physicians moved their practices to New Jersey, joined our Society, and applied for insurance in our program.

In Utah, the problem was wholesale cancellations by various companies. When rates were increased more than thirteen times, some of the companies resumed their underwriting.

Apparently, professional liability has become a major problem because the losses reflect not only medical problems but also legal and social ones. Underwriting losses have been reported to be substantial. At a meeting in Pennsylvania, the Pacific Indemnity Company said it lost about $10 million in a period of five years in California. Aetna Casualty and Surety estimated its losses in 1968 to be about $10 million nationwide.

Even with substantial rate increases, the market for this coverage has tightened, particularly for the specialties of orthopedics, anesthesiology, and surgery. One group of anesthesiologists in Pennsylvania could get coverage only from Lloyds of London. In its new policy, Lloyds has eliminated one of the worst problems facing American companies, which is the delay in knowing what losses will be.

In our policy, there is coverage for an act occurring during the policy period, whether the claim or suit is reported two, ten, or twenty years later. Employers state it is almost impossible to establish reserves to cover a long period. With frequent late reporting, it doesn't know if it has adequate rates based on past experience and it takes five to seven years or more to know the true experience.

Lloyds solved this problem by giving coverage on a "claims made basis." For its coverage to apply, the alleged act of malpractice must occur during the policy period, and the claim or suit must be filed within three years, provided coverage continues without termination. However, if the policy is canceled or not renewed, there is no coverage for any claim or suit filed after termination of the policy. This makes rates more responsive to current experience but leaves the physician without coverage for latent claims or suits which constitute more than 50 per cent of those reported.

In March 1970, the committee mailed to each member the booklet "Medical Malpractice—The Insurance Scene" by Dunbar R. Uhthoff, vice-president and actuary of Employers Insurance of Wausau. Each physician should have read this excellent explanation of the malpractice insurance problem. For those who may not have had time to read it, we wish to refer to a few statements:

"The effect upon the medical community of claims for malpractice is simply getting out of hand. The standards demanded by our courts and juries continuously change and usually toward even greater liberality, thus reflecting the changing attitudes of our dynamic but increasingly permissive society. The restraints tend to inexorably impel the physician toward a safe mediocrity.

"There is both direct and indirect inflationary effect on medical bills. The physician 'plays it safe' with tests, consultations and other defensive measures which were unnecessary a few years ago. In a few instances there are benefits for the patient, but the cost of medical care increases; and indirectly, in the long run, the patient picks up the whole malpractice check. Physicians like other business men, must pass their operating costs, including insurance, along to their customers.

"There is alarm as well as confusion. As insurance companies find the medical malpractice exposure more complex, difficult and expensive, the market becomes more severely limited. Additional companies have retired from this form of insurance in the past year. There are few who consider it their responsibility to find ways and means of providing protection.

"While the company and the physicians deplore the step-by-step escalation of rates, the steps must be taken until we reach a platform, a leveling-off place from which we may hope to begin a descent.

"The insurance cost problem from the insurance company viewpoint is simply a matter of losses increasing faster than premium rates. To physicians, insurance specialists are laymen. To an insurance company actuary, it's the physician who is the layman."

At our meeting to review rates and changes in January 1970, Mr. Britton gave us a report explaining the changes in rates and costs. His report is as follows:

Rates for 1970

The Insurance Rating Bureau (the rate-making agent for stock insurance companies which write 75 per cent or more of the malpractice insurance in this country) has filed for rate increases to over 100 per cent in most states. In addition, it has filed for another upward revision in factors for limits in excess of the base rate for $5,000 limits. These increases are 25 per cent for non-surgical and 75 per cent for surgical coverage. The changes produce rate increases over-all of from 50 per cent to 200 per cent.

Employers, at our meeting on 16 December, initially wanted an increase of 50 per cent in the base rate and the IRB increases in excess limits factors of 25 per cent and 75 per cent. This would have increased our current costs, at $100,000/$300,000 limits, 100 per cent for non-surgical and 119 per cent for surgical classes. After a day and a half of discussion, it was determined that the minimum the company would accept was an increase of 15 per cent in the base rate and an increase in the

excess limits factors of 25 per cent for non-surgical and 50 per cent for surgical. This has an effect of an increase in costs for $100,000/$300,000 limits of about 32 per cent for classes 1, 2, 6 and 7 and 50 per cent for classes 3, 4 and 5.

Comparing this final result to what is happening in the malpractice field nationally, the increase is lower than should be expected and considerably lower than could have been demanded under present circumstances.

Although aware of our national trend, our committee asked for information as to actual experience in New Jersey. Mr. Britton's report on this subject is as follows:

Our experience with Employers Insurance of Wausau actually started on 1 November 1968, although a few policies were issued prior to that date. The time is too short for a conclusive or even meaningful analysis. However, the trend in New Jersey is such that the Senior Vice-President and Underwriting Manager of the company stated that if today's knowledge had been at hand two years ago, it is doubtful that it would have undertaken this business in New Jersey. Fortunately for our members, there is no thought by the company of deserting us. It agrees with me that it has a responsibility to work with us until this trend has stopped or been reversed.

The frequency ratio of claims reported, as compared to the number of physicians insured in New Jersey for the past year, shows a trend 20 per cent higher than in New York. As of 30 September 1969, the average cost per case in New Jersey was $12,000 which is about 10 per cent higher than the case average in New York. The New York rates are higher than those in New Jersey.

When the company's loss ratio exceeds 80 per cent, it loses money and rates must be increased accordingly for the company to continue providing insurance protection. The company's loss ratio for New York for the nineteen years, from 1949 through 1968, is 120 per cent or 40 per cent higher than permissible. For the past five years, the average loss ratio is 143 per cent. Consider those figures in light of the indicated trend in New Jersey as being worse than in New York and in the light of continued lower rates in New Jersey.

A survey was made of claims reported in our program since 1960. We have no records of those reported in 1969 to our previous carrier nor of reports made by physicians not insured under our program. The survey clearly indicated a trend in 1969 greater than the 20 per cent in excess of New York reported by Employers.

For comparison of rates in New Jersey it may be of interest to our members to know that the insurance company underwriting the national osteopathic program through the Nettleship Company in Los Angeles filed new rates for New Jersey. They were approved by the New Jersey Commissioner of Insurance effective 1 January 1970. The new rates and factors for coverage of $100,000 per claim and $300,000 aggregate will cost almost $2,000 for non-surgical practices and almost $14,000 for surgical. Their rates are about six times our new rates.

There were some changes in classes and rules to be effective for new members as of 1 May 1970. They are as follows:

1. Class 6 rate is 60 per cent of class 1 rate. Class 6 is for physicians retired and for pharmaceutical or insurance company employees. The rate will be increased to 75 per cent of class 1 rate and retired physicians will be moved from class 6 to class 7.

2. Establish a new class 7 with rate of 50 per cent of class 1 rate.

3. Move from class 1 to class 6 the physicians whose specialties are physiatry, preventive medicine, psychiatry, public health, and rehabilitation.

4. Move from class 1 to class 2 the specialtics of radiology and roentgenology.

5. Move from class 4 to class 5 the specialty of plastic surgery.

6. Reduce the charge for x-ray therapy by dermatologists from 75 per cent of class 1 rate to 50 per cent of class 1 rate.

7. Reduce the charge for x-ray therapy, other than by dermatologists, from 100 per cent of class 1 rate to 75 per cent of class 1 rate.

8. Reduce the charge for electro-convulsive therapy from class 2 rate to class 1 rate, which is a 33 per cent reduction.

During the past year, the committee again reviewed the matter of making available our insurance program to members who are not practicing in New Jersey, including those in military service. Our position has not changed. For the good of our society and continued success of our program, insurance will be available only to those members whose practice time is 50 per cent or more in New Jersey.

The committee reviewed the question of offering our endorsed catastrophe (umbrella) policy to members whose coverage is not written under the program. This excess coverage shall be available only to those members who have their malpractice policies under the program.

The meeting between the Conference Committee with the Bench, Bar and the Supreme Court Committee on Relations with the Medical Profession indicated awareness by the Court of our serious problem and of a willingness to cooperate. Our committee asked for a joint meeting with representatives of the Council on Legislation to evaluate suggestions for Court Rules changes or remedial legislation. Those suggestions which are found to have merit will be referred for further consideration and action.

The surcharge program was approved last year. It provided for surcharges as high as 500 per cent for those physicians reporting suits of malpractice beyond the permissible limit as to number and time. On 1 November 1969, the company surcharged fifteen physicians involving ten different counties.

At first glance this report may seem to be unpleasant. However there should be great satisfaction for our members when they realize the success of our program. We don't have the lowest rates but we do have insurance available to all our members. The program is underwritten by a very large and reputable insurance company which plans to stay with us for a long time. We must accept rates which appear to be reasonable and necessary to reflect a possible reasonable profit for the company.

The committee is disappointed with the participation by our members in our program. We cannot understand why we don't have 100 per cent of our eligible members (those practicing in New Jersey) insured. The participation as of 1 March 1970 is as follows:

County	Eligible	Insured	Percent
Atlantic	172	68	40
Bergen	841	643	76
Burlington	841	105	59
Camden	392	260	66
Cape May	37	17	46
Cumberland	98	55	56
Essex	1,517	1,125	74
Gloucester	85	44	52
Hudson	506	404	80
Hunterdon	51	50	98
Mercer	466	195	42
Middlesex	407	319	78
Monmouth	398	259	65
Morris	389	271	70
Ocean	130	103	79
Passaic	575	462	80
Salem	45	4	9
Somerset	135	93	69
Sussex	46	43	93
Union	629	505	80
Warren	42	21	50
Total	7,138	5,046	71

Recommendations

(1) That the Joseph A. Britton Agency be redesignated as The Medical Society of New Jersey's official broker for its professional liability coverage.

(2) That Employers Insurance of Wausau be continued as the official professional liability insurance carrier for The Medical Society of New Jersey for 1970-1971.

Approved with notations (page 431)

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Medical Education

Morris H. Saffron, M.D., Chairman, Passaic

(Reference Committee "D")

The Committee on Medical Education held a reorganization meeting on 10 December 1969, and met again on 11 January and 15 March, 1970. Discussions centered about such topics as the threat of re-examination as recommended by the President's Commission on Manpower, the resulting sense of urgency which led to the AMA's Recognition Award for Continuing Education, and the part which the Medical Society should play in attempting to counteract physician obsolescence. The committee felt that while the Recognition Award might be ineffectual in stimulating the individual laggard, and might even be open to abuse, it was a step in the right direction. Upon recommendation of the committee the Recognition Award program was approved by the Board of Trustees 18 January 1970.

In this connection the committee recognized and approved the pioneering effort of the American Academy of General Practice. The continuing program of the Academy of Medicine of New Jersey was also approved. The committee also approves of the efforts being made by the Committee on the Annual Meeting to expand and improve the Scientific Sessions through collaboration with the various specialty societies in the state.

The committee also took careful cognizance of the expanding efforts of the two medical schools and of the Association of Directors of Medical Education in the field of continuing education. Until now there has been no concerted effort to coordinate the activities of various groups involved in this discipline.

The committee felt that The Medical Society of New Jersey must not fail to carry out a constitutional obligation to maintain an effective posture in the field of medical education. Responsibility for such a task can no longer be relegated to a committee, no matter how well motivated. If the Society wishes to act in a supervisory capacity, some other mechanism must be established.

Approved with notations (page 432)

Medical Student Loan Fund

Frank J. Hughes, M.D., Chairman, Camden

(Reference Committee "B")

In its thirteen years of operation the Medical Student Loan Fund has granted loans totaling $248,244.35 including $444.35 as insurance payments, bringing the net loans granted to $247,800.

To date the Fund has issued 243 loans to 145 New Jersey medical students. Forty-two loans have been repaid in full. Twenty borrowers are presently making quarterly repayments on an annual basis, and two borrowers are presently making interest payments only.

Requests for financial assistance by New Jersey medical students has notably increased during the 1969-70 administrative year. It is expected that this trend will continue for some time. Out of a total of twenty-three student requests, eighteen were granted loans of $1,500 and one at $1,000, for a total of $28,000.

It is estimated that the Fund will have $30,000 available for loans for the 1970-71 school year. Of this amount, $19,500 is

committed to prior applicants, leaving $10,500 for new student requests. Applications and inquiries received to date from qualified seniors and juniors alone total $22,500. Thus, a shortage of $12,000 is anticipated.

Your committee has had encouraging results from its solicitation of past loan recipients now serving an internship or residency to initiate early repayment of their loans on an interest-free basis.

The financial activities of the Fund during the year are included in the report of the Treasurer.

The committee warmly commends and thanks Mr. Lambert and Mr. Squreck for their consistently efficient administrative assistance.

Present Location of Recipients of Loans

The 96 graduates are located as follows:

Interns—1 in New Jersey and 3 out-of-state	4
Residents—14 in New Jersey and 24 out-of-state	38
Armed Service—29 Army of the United States and 5 United States Navy	34
Private Practice—9 New Jersey, 1 Tennessee, 3 Pennsylvania, 1 District of Columbia, 1 California, 1 Massachusetts, 1 Oregon, 2 Connecticut, and 1 New York	20
Students presently in medical school—8 seniors, 7 juniors and 4 sophomores	19
Current student loans outstanding	115
Medical students paid in full (42 loans)	30
Total New Jersey Medical Students (as listed earlier)	145

Distribution of Loans

County of Residence	Medical School	Students	Loans Granted 1957-1969	Loans Granted 1969-1970 March 31, 1970
Atlantic	Hahnemann	3	$ 3,000.00	
	N. J. Medical	1	1,000.00	
	Pittsburgh	1	2,000.00	
	Temple	1	1,000.00	
	Tufts	1	4,000.00	
Bergen	Boston	1	1,000.00	
	Creighton	1	1,000.00	
	Hahnemann	3	5,000.00	
	Jefferson	1		$ 1,500.00
	N. J. Medical	7	11,000.00	
	N. Y. Medical	1	1,000.00	
	St. Louis	1	1,500.00	
Burlington	Duke	1	$ 4,000.00	
	Hahnemann	1	1,000.00	
	Jefferson	3	3,500.00	$ 3,000.00
Camden	Jefferson	3	2,000.00	3,000.00
	Michigan	1	2,000.00	
	N. J. Medical	2	2,700.00	
	Temple	5	6,000.00	1,500.00
	Hahnemann	2	2,000.00	
Cumberland	Jefferson	1	2,000.00	
Essex	Albany	1	4,000.00	
	Bern	1	2,000.00	
	Duke	1	2,000.00	
	Hahnemann	3	6,500.00	1,500.00
	Howard	1	300.00	
	Jefferson	1	1,500.00	1,500.00
	N. J. Medical	10	16,500.00	4,000.00
	N. Y. Medical	2	2,000.00	
	Stanford	1		1,500.00
	St. Louis	1	500.00	
	Temple	1	1,000.00	
	Georgetown	1	1,000.00	
Gloucester	Hahnemann	1	1,000.00	
	Temple	1	2,000.00	
	U. of Virginia	1	1,000.00	

County of Residence	Medical School	Students	Loans Granted 1957-1969	1969-1970 March 31, 1970
Hudson	Georgetown	1	1,000.00	
	George Washington	1		1,500.00
	Harvard	1	1,000.00	
	Howard	1	400.00	
	N. J. Medical	18	26,150.00	
	N.Y. Medical	1	1,000.00	
	Pittsburgh	1	3,000.00	
	St. Louis	1	2,000.00	
Mercer	Hahnemann	2	3,000.00	
	Howard	1	1,000.00	
	Johns Hopkins	1	1,000.00	
	Meharry	1	250.00	
	Mississippi	1	3,000.00	
	N. J. Medical	5	9,500.00	
	N. Y. Medical	1		1,500.00
	U. of Penna.	1	1,000.00	
	St. Louis	1	700.00	
	U. of Louisville	1	1,500.00	1,500.00
Middlesex	Georgetown	1	1,500.00	
	Hahnemann	1	4,000.00	
Monmouth	Columbia	1	2,000.00	
	Georgetown	1	1,000.00	
	Jefferson	1	3,000.00	
	Marquette	2	2,000.00	1,500.00
	N. J. Medical	3	8,500.00	1,500.00
	N. Y. Medical	1	4,000.00	
	Stritch, Loyola	1		1,500.00
	Temple	1	2,000.00	
	Up-State N. Y.	1	1,000.00	
Morris	Dartmouth	1	1,000.00	
	Duke	1	1,000.00	
	N. J. Medical	1	3,000.00	
Passaic	Jefferson	1	3,000.00	
	N. Y. Medical	1	1,000.00	
Salem	Duke	1		1,500.00
Somerset	Georgetown	1	1,000.00	
	N. Y. Medical	1	2,000.00	
	Temple	1	3,000.00	
	Western Reserve	1	1,000.00	
Union	Florida	1	1,000.00	
	Hahnemann	1	1,000.00	
	Jefferson	1	1,500.00	
	N. J. Medical	11	17,800.00	
16 Counties	31 Medical Schools	145	$219,800.00	$ 28,000.00
	Total loans granted 3/31/70			$247,800.00

Contributions

The committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

General Fund

The Medical Society of New Jersey, Board of Trustees; MSNJ's Woman's Auxiliary Executive Board; Fellowettes of Woman's Auxiliary to MSNJ; Hudson County Medical Society; County Woman's Auxiliaries: Atlantic, Bergen, Burlington, Camden, Cape May, Essex, Gloucester, Mercer, Middlesex, Monmouth, Ocean, Passaic, Salem, Union, and Warren. Samuel and Ethel Bernson, Dr. Nicholas A. Bertha, Beth Israel Hospital Social Service Department, Dr. and Mrs. Victor Boogdanian, Dr. and Mrs. Jules Cooper, Dr. and Mrs. Robert Cornwell, Mr. and Mrs. Theodore Dapkey, Dr. and Mrs. Salvatore J. De Cicco, Dr. and Mrs. William E. Dodd, Dr. and Mrs. S. S. Ellenson, Mrs. Vincenza Jasper, Dr. and Mrs. Joseph R. Jehl, Mrs. Henrietta Kicherer, Dr. and Mrs. John F. Kustrup, Mr. and Mrs. Harry A. Leonard, Dr. and Mrs. Samuel J. Lloyd, Dr. and Mrs. Edward O. MacDonald, Mrs. Salvatore Mancinelli, Mrs. Paul Melrose, Mr. and Mrs. August Muller, Dr. and Mrs. Luke A. Mulligan, Dr. and Mrs. Richard N. Outwin, Dr. and Mrs. Paul H. Pettit, Dr. and Mrs. Carl Records, Dr. and Mrs. Thomas Rein, Dr. and Mrs. Norman Rosenberg, Mrs. Joseph Santangelo, Dr. and Mrs. John S. Van Mater, Mrs. H. Roy

Van Ness, Mrs. Frances K. Wald, Mrs. Shirley M. Walsh, Women's Golf Association Ocean City Somers Point Country Club.

In Memory Of

Peter Amirata, Sr., Mrs. Donald Barth, Mrs. Elizabeth Rowohlt Barth, Joseph Berg, Mrs. Anna Bornstein, Frank Bortone, Edwin T. Bruce, Jr., M.D., D'Arcy C. Claire, M.D., John J. Danielson, M.D., Jimmy Ellenbogen, Harrison English, M.D., William E. Everett, Mrs. Benjamin Gencher, Ben Goldstein, M.D., Mrs. Elizabeth Graulich, Lloyd A. Hamilton, M.D., George Hatcher, M.D., Miss Honoiah Henderson, Otto Holters, M.D., Bartley M. Howley, M.D., Mrs Ibranyi, Jimmy Johnson, Mrs. Grace Kaufman, Mrs. Thelma Kiel, James Lafferty, Mrs. C. C. Long, Ralph Maio, M.D., George Meyer, Mrs. Johanna Moleson, Mrs. Harrold A. Murray, Mrs. Ronald Nayfield, Anthony Pepe, Charles W. Potter, M.D., Mrs. Richard S. Rude, Roy R. Schubert, M.D., Mrs. J. R. Becky Schwartz, Mario Sciorsci, M.D., Sarah Patricia Sharpe, Mr. George B. Shick, Peter Simeone, M.D., Guiseppe Spinelli, Walter S. Straus, M.D., Mrs. Jacqueline Towns, Marian Wallace, Veneta Weaver, John Hogate Whiticar, M.D.

In Honor Of

Mrs. Alexander U. Bertland, Mrs. Edward MacDonald, MSNJ's Woman's Auxiliary Executive Board.

Recommendations

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee—approving a budget appropriation of twelve thousand dollars in lieu of a special per capita assessment for 1970-71 in support of the Medical Student Loan Fund.

(b) That the MSNJ membership be urged to continue their active support by sending contributions to the Fund.

(c) That the Woman's Auxiliary to The Medical Society of New Jersey be requested to make the Fund its number one project next year.

Approved with recommendation (page 430)

Publication

George B. Sharbaugh, M.D., Chairman, Trenton

(Reference Committee "B")

As shown in the tabulation below, *The Journal* is publishing an increasing percentage of "text" material—defined as "everything except advertising." The proportion of text to total pages fluctuates narrowly around the 50 per cent point. If we go beyond a certain ratio of advertising, our postal rates will go up, and we open the door to possible income tax assessments (because we might then be construed as a profit-making enterprise). If we go below a certain ratio, we lose income.

	1966	1967	1968	1969
Total Text Material	578	704	708	720
Advertising	660	788	714	616
Total Pages	1238	1492	1422	1336
Ratio: Text/Total	47%	47%	50%	54%
Ratio: Advertising/Total	53%	53%	50%	46%

During the calendar year 1969 there was, throughout the country, a decrease in the budget made available by the pharmaceutical industry for medical journal advertising. This is due to several factors related to tighter FDA standards for drug advertising, increasing caution at introducing new products, and the competition of other methods of promoting new pharmaceuticals—direct mail, visits of detailmen, and exhibits at medical conventions. In our specific case, we have clung (perhaps rather stubbornly) to the policy of not having advertising and text (editorial, scientific, or news items) interspersed. We are one of the few medical journals to adhere to this policy, and we have had the experience of losing advertising because the advertisers, especially pharmaceutical manufacturers, specify that their promotional material be placed "next to reading matter." Our Committee is going to consider a possible policy change in this area at an early meeting this year.

The amount of text material has increased in the last four years, from 578 pages in 1966 to 720 pages in 1969. Even so, we have to reject many scientific articles and news items simply

because of lack of space. One of the Committee's major decision has to be to strike a balance between advertising space and text space.

We are now giving a page a month to news from the New Jersey College of Medicine and Dentistry. We will be happy to do the same for the medical school at Rutgers, if they wish it. The Department of Health's news items have been submitted regularly and have proved to be an interesting feature of each issue.

Our office runs smoothly, though with only one full-time employee there (Mrs. Treptow, the Assistant Editor) it is only a mini-office. Actually, we have a much smaller staff than many state journals of lesser size and circulation. In this year, as in previous years, Mr. Cookson has proved himself to be a dynamic advertising manager who has consistently subordinated interest in getting advertising to the ethical proprieties. And we are fortunate in retaining Dr. Davidson, who, in spite of his return to private practice in 1969, continues to give us the time we need, and who enjoys an enviable reputation in the field of medical journalism.

For the rest, your Committee says little. *The Journal* speaks for itself.

Approved with commendation to the Editor (page 430)

Revision of Constitution and Bylaws

Fred A. Mettler, M.D., Chairman, Blairstown

(Reference Committee on Constitution and Bylaws)

During the past year only five proposed amendments to the Bylaws were submitted. Listed in detail below are the five proposed amendments to the Bylaws as submitted by the Board of Trustees and the actions we have recommended:

Exhibit #1

The committee essentially agrees to the following proposed amendment to Chapter II, Section 3 of the Bylaws

Chapter II — Meetings

Section 3 — Rules of Order

Current	*Proposed*
The deliberations of this Society shall be governed by parliamentary usage as contained in Roberts' "Rules of Order, Revised," when not in conflict with the Constitution and Bylaws.	The deliberations of this Society shall be governed by parliamentary usage as contained in *Sturgis' "Standard Code of Parliamentary Procedure,"* when not in conflict with the Constitution and Bylaws.

Proposed revision amended by Reference Committee to read: (amendment indicated by italics)

The deliberations of this Society shall be governed by parliamentary usage as contained in Sturgis' "Standard Code of Parliamentary Procedure," *latest revision,* when not in conflict with the Constitution and Bylaws.

Approved as amended by the Reference Committee (page 443)

Exhibit #2

The committee essentially agrees to the following proposed amendment to Chapter V, Section 1, paragraph (d) of the Bylaws

Chapter V — Procedure of Election

Section 1 — Nominating Committee

Current	*Proposed*
(a) Each component society shall elect, at any meeting prior to March 31 of the fiscal year, one (1) of its elected delegates to serve as a member of the Nominating Committee at the next annual	Same

meeting of this Society. At the same time, each component society shall elect one (1) of its elected delegates to serve as the alternate member of the Nominating Committee.

(b) The elected member of the Nominating Committee, or in his absence the alternate member of the Nominating Committee, shall present his credentials to the Secretary at the close of the first session of the House of Delegates at the annual meeting.

Same

Amended by Reference Committee to read: (amendment indicated by italics)

(b) The elected member of the Nominating Committee or in his absence the alternate member of the Nominating Committee, shall present his credentials to the Secretary *before the scheduled meeting of the Nominating Commitee.*

Approved as amended by the Reference Committee (page 443)

(c) The Immediate Past-President of this Society shall be a member of the Nominating Committee representing the Fellows. If he shall not be able to serve, then at the close of the first session of the House of Delegates, the Fellows shall elect one of their number to be a member of the Nominating Committee. He shall forthwith present his credentials to the Secretary.

Same

Amended by Reference Committee to read: (amendment indicated by italics)

(c) The Immediate Past-President of this Society shall be a member of the Nominating Committee representing the Fellows and *shall* serve as *Chairman*. If he shall not be able to serve, *his immediate predecessor shall serve in his stead.* He shall forthwith present his credentials to the Secretary.

Approved as amended by the Reference Committee (page 443)

(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the Nominating Committee. This Committee shall meet in the evening of the first day of the annual meeting and report the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled, including Trustees, elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations.

(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the Nominating Committee. This committee shall meet *within the two-week period prior to the opening session of the House of Delegates* and report the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled, including Trustees, elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, Delegates and Alternate Delegates to other medical organizations.

Not approved. Recommitted to the Standing Committee on Revision of Constitution and Bylaws (page 443)

Exhibit #3

The committee essentially agrees with the following proposed amendment to Chapter V, Section 3, Paragraph (d) of the Bylaws

Chapter V — Procedure of Election

Section 3 — Report and Election

Current	*Proposed*
(a) The report of the Nominating Committee, the submission of nominations from the floor by members of the House of Delegates—if any—and the election shall constitute the principal business of the second session of the House of Delegates.	Same
(b) All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.	Same
(c) In the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped. Balloting shall be repeated until an election is made.	Same
(d) When a member who already holds an elective office is elected to a second office, the presiding officer shall then declare the previous elective office vacant. This vacancy shall then be filled immediately by nomination from the floor and election by the House of Delegates.	*(d) When an incumbent elected officer, as defined in Article IV, Section 3 of the Constitution, is elected to serve as an officer in another capacity,* the presiding officer shall then declare the previous elective office vacant. This vacancy shall then be filled immediately by nomination from the floor and election by the House of Delegates.
(e) The President-Elect shall advance to the office of President without process of nomination and election.	Same

Approved (page 443)

Exhibit #4

The committee essentially agrees with the following proposed amendment to Chapter VII, Section 4, paragraph 4 of the Bylaws

Chapter VII — Judicial Council

Section 4 — Duties of the Judicial Council

Current	*Proposed*
The duties of the Judicial Council shall be as follows:	Same
1. To sit as an appellate tribunal and to hear and determine any and all appeals properly brought before it from any county judicial committee;	Same
2. To interpret and rule upon all questions of an ethical nature that shall confront the House of Delegates or any other board or committee of this Society;	Same
3. To adjudicate all disputes or controversies arising within The Medical Society of New Jersey;	Same
4. To receive complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate county judicial committee;	4. To receive *inquiries,* complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate county judicial committee;
Approved (page 443)	
5. To receive, consider and rule on any matter of discipline concerning any member or members of this Society brought to it on appeal from a county judicial committee;	Same
6. To make and promulgate from time to time such rules and regulations as in its opinion may be necessary to insure the proper functioning of the Judicial Council and the various county judicial committees with reference both to the substance and procedure of hearings had by the Judicial Council and such county judicial committees. Upon receipt of such rules and regulations by the various county judicial committees the members of said committees shall be bound thereby.	Same

Exhibit #5

The committee essentially agrees with the following proposed amendment to Chapter XI, Section 4, paragraph (c) of the Bylaws

Chapter XI — Component Societies

Section 4—Associate Members

Current	*Proposed*
(a) Except in the case of transferred membership, each component society must require applicants to serve a probationary period of one (1) to two (2) years as associate members.	(a) Same
(b) Associate members shall have such privileges in component societies as the constitution and bylaws of the respective societies may provide, except the right to vote and hold office.	(b) Same
(c) Associate members shall be assessed two-thirds (2/3) of the current per capita assessment.	(c) Associate members shall be assessed *the current per capita assessment.*
Approved (page 443)	
Approved as amended by the Reference Committee (page 443)	

A National Nutrition Policy?

Philip L. White, secretary of the AMA Council on Foods and Nutrition, told the Senate Committee on Nutrition recently that, "The United States needs to develop a national nutrition policy. Goals in food production and distribution, the establishment of adequate levels of nutrient intake for individuals and groups of people, and plans for the nourishment of our future expanded populations are but a few of the issues which require national attention."

Woman's Auxiliary Advisory

Keith R. Young, M.D., Chairman, Burlington
(Reference Committee "H")

The official programs and projects of the Woman's Auxiliary to The Medical Society of New Jersey for 1969-70 were submitted to and approved by the Board of Trustees of the Society at its meeting on 20 July 1969. The work of the Auxiliary was so efficiently planned and carried out that there was no need for a formal meeting of this committee in the course of the year.

The programs of the Woman's Auxiliary to The Medical Society of New Jersey are all intended to serve in a supporting capacity the programs and purposes of The Medical Society of New Jersey and its component societies. This arises from the fact that—as the name implies—the function of any auxiliary is to aid and lend assistance to the body to which it is attached.

For that reason the approved programs of the Woman's Auxiliary—at state and county levels—are formulated and carried out only with the approval of and in cooperation with the parent Medical Society.

Proposals for Auxiliary participation are weighed and considered in this light. Unless they are consonant with, and are approved by, the Medical Society—at state and local level—they cannot be considered.

The 1969-70 program was identical with that of 1968-69 except that the separate Disaster Preparedness and Safety programs were combined under the title of Program on Safety-Disaster Preparedness, and a new program on Children and Youth was added.

The committee commends the Woman's Auxiliary for its many valuable activities and expresses appreciation to its officers and members for their continued support of The Medical Society of New Jersey in its efforts to protect the health and welfare of the people of New Jersey.

Approved with commendation to the Auxiliary (page 442)

Teaching About Drug Addiction

The New Jersey College of Medicine and Dentistry has embarked on an intensive program of teaching teachers in the field of drug addiction. The backbone of the program will be the development of three-week, in-depth courses taught by specialists from around the country. Ex-addicts will participate in the teaching, describing the drug scene through the eyes of disenchanted abusers. It is planned to have about 50 students in each course. The course material will include seminars, lectures, motion pictures, visits to therapeutic centers, counseling sessions, and workshops. Each participant will receive a book of information, including a glossary of drug terminology, a description of community services, abstracts of recent articles, and listings of new drugs.

The program is funded in part by grants from Sandoz, Inc. and the National Newark and Essex Bank. Dr. Edward Wolfson, the Medical Director of the College's Division of Drug Abuse, has said, "Gifts such as these from community-minded organizations and institutions will make it possible to extend (these) services throughout the State."

Administrative Council

Legislation

Jesse McCall, M.D., Chairman, Newton

(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern to the Society in the 1969 legislative year and a record of the bills of medical interest in the 1970 Legislature thus far, together with a brief description of, and the Society's official position on, each piece of legislation. The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies and in items published in the *Membership Newsletter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The 193rd (1969) session of the New Jersey Legislature was adjourned *sine die* at noon on 13 January 1970. There were 855 bills introduced in the Senate and 1,124 bills in the Assembly. In addition, the Senate considered 103 resolutions of various types and the Assembly considered 141. The total of all legislative measures in the session reached 2,223, an increase of 78 bills over the 1968 session of the legislature.

The Council on Legislation took a position on 172 measures as bearing directly upon the Society's interest and concern. Of this total: (a) 1 bill actively supported became law; (b) 15 bills approved were signed into law; (c) 1 bill disapproved by MSNJ became law; and (d) 4 bills on which MSNJ had a position of no action were enacted; (e) 3 bills approved by MSNJ were vetoed; (f) 1 bill disapproved was vetoed; and (g) 1 bill on which MSNJ had a position of no action was vetoed.

Actively Supported Bill Signed Into Law

S-350 —To authorize the school medical inspector to accept the report of physical examination of a pupil by his treating physician.

Approved Bills Signed Into Law

S-45 —To permit county appropriations for the benefit of brain-injured persons to defray expenses incident to diagnosis, treatment and training.

S-222 —To authorize the chief executive officer of a state or county institution for the mentally ill or retarded or of a state or county penal or correctional institution to give consent for treatment of incompetent patients or inmates under 21.

S-337 —To provide for the construction of Community Mental Health Center to be managed by the New Jersey College of Medicine and Dentistry.

S-481 —To provide for licensing of any applicant to practice medicine and surgery who can establish he has been examined and licensed by certificate of the National Board of Examiners for Osteopathic Physicians and Surgeons.

S-769 —To establish in the Department of Health a program for the care of persons suffering from chronic renal diseases; to provide for an advisory committee and to appropriate $250,000.

S-814 —To define "school of professional nursing" to mean a school offering a program of nursing instruction not exceeding 4, in place of 3 years.

A-137 —To authorize gifts of all or part of a human body after death for advancement of medical science or replacement or rehabilitation of diseased or worn-out parts or organs.

A-180 —To delete from the act concerning assistance for dependent children the provision that a determination of a right to financial assistance by reason of unemployment or underemployment of parents shall not constitute such persons of assistance, to make them eligible for coverage under the "New Jersey Medical Assistance Act."

A-181 —To delete from the public assistance act the provision that any grant of old age assistance shall make recipients thereof ineligible for coverage under the "New Jersey Medical Assistance Act."

A-271 —To establish a Division of Narcotic and Drug Abuse Control in the Department of Health.

A-328 —To provide that the name of a corporation organized under "The Professional Service Corporation Act" shall contain a name descriptive of the type of professional service in which it is engaged.

A-327 —To permit any person, including his insurer, to make payment to, or on behalf of, a potential plaintiff for losses or expenses resulting from any accident, without admission of liability.

A-989 —To define "qualified applicant" under the medical assistance act to include a child in foster placement under supervision of the Bureau of Children's Services whose maintenance is being paid in whole or part from public funds and to permit any approved claims for health services rendered on or before December 31, 1969 to recipients of old age assistance, assistance for the permanently and totally disabled, assistance for the blind or for dependent children to be paid on or before June 30, 1970.

A-990 —To delete the one year state residency requirement for old age assistance and to eliminate ineligibility for such assistance on the basis of residency in any public or private medical institution other than a hospital.

A-991 —To provide that medical assistance for the aged shall be administered by the Department of Institutions and Agencies; to provide for a hearing when a claim for medical assistance is denied or not acted upon promptly; to provide that the State shall provide funds to meet expenditures; to provide that the State shall pay reasonable costs incurred by county welfare boards in investigating and determining whether applicants are eligible for aged medical assistance under standards prescribed by the Department of Institutions and Agencies.

Disapproved Legislation Signed Into Law

A-448 —To delete the December 31, 1969 termination date applicable to prohibitory provisions concerning the practice of medicine and surgery from which exemption may be granted to doctors employed on the medical staff of a state agency.

No Action Legislation Signed Into Law

S-408 —To provide that the Board of Trustees of the New Jersey Medical and Dental College shall consist of 9 instead of 7 members.

S-424 —To provide that any applicant for a chiropractic license must have completed no less than one and one-half years of study in accredited school or college of arts and sciences before commencing study in the approved school of chiropractic.

A-703 —To increase the maximum and minimum penalties for violations of health ordinances.

A-820 —To provide for 7, in place of 5, nursing home administrators on the Nursing Home Administrators Licensing Board, two of whom shall be administrators of governmentally operated nursing homes and two shall be from non-profit homes for the aged with licensed infirmaries.

Approved Bills Vetoed

S-356 —To provide a penalty for operation of a motor vehicle by a person under the influence of marijuana.

A-614 —To provide that the requirement of a certificate under the act concerning regulation and certification of x-ray technicians shall not apply to licensed dentists and persons who operate under a licensed dentist's supervision only x-ray equipment designed for dental radiographs.

A-811 —To provide that no licensee shall collect blood for transfusions and pay a consideration therefor unless, prior to phlebotomy, the donor is examined by a physician.

Disapproved Bill Vetoed

A-371 —To provide that any person employed in a county narcotics clinic as a psychiatric social worker and/or social worker in a narcotics clinic who assumes responsibility of the Director in his absence and attends meetings in his place and who has trained and instructed others and worked for a clinic for 18 months and with the Narcotics Commission for 5 years shall be eligible for appointment as Assistant Director.

No Action Bill Vetoed

A-961 —To require the Department of Institutions and Agencies to notify the Senate and General Assembly Appropriations and Institutions and Welfare Committees and the Legislative Budget and Finance Director at least 90 days prior to the adoption and announcement of any change in the basic formula upon which assistance grants are determined for any public or general assistance program.

Status of Other Bills of Significant Interest

S-157 —To permit the Board of Medical Examiners to grant a license for practice of medicine and surgery without further examination where an applicant shows he has been examined and licensed in a foreign country. . . . Actively opposed by MSNJ. Bill did not come out of Senate committee to which it was referred.

S-192 —To provide for public representation on all professional boards. . . . Actively opposed by MSNJ. Did not come out of Senate committee to which it was referred.

S-365 —To provide for the confidentiality of information and data secured by and in possession of hospitals or extended care facility utilization review committees. . . . Actively supported by MSNJ. Bill did not come out of Senate committee to which it was referred.

S-818 —To protect rights of owners in the ownership of dogs and other animals, to provide for control and licensing requirements with rela-

tion to dogs and for the humane care, transportation and handling of dogs and other animals. . . . Actively opposed by MSNJ. Bill did not come out of Senate committee to which it was referred.

A-322 —To repeal the gross receipts excise tax on unincorporated businesses. . . . Actively supported by MSNJ. Bill did not come out of Assembly committee to which it was referred.

A-589 —To create a Governor-appointed commission, known as the Rutgers South Jersey Medical and Dental College Planning Council, to choose a site for a medical-dental school in South Jersey. . . . Actively supported by MSNJ. Bill did not come out of Assembly committee to which it was referred.

A-1054—To require boards of education to retain an optometrist or a diplomate of the American Board of Ophthalmology licensed to practice medicine and surgery. . . . Actively opposed by MSNJ. Bill did not move out of Assembly committee to which it was referred.

Society-Supported Legislation Thus Far Introduced (1970 Session)

S-258 —To provide for the confidentiality of informa-
S-559 —tion and data secured by and in the possession of utilization review committees established by hospitals or extended medical care facilities. . . . Re-introduced on 13 January 1970 as S-258 by Senator Wallwork (Essex). Referred to the Senate Committee on Commerce, Industry and Professions. On 9 February 1970 Senator Wallwork introduced S-559 an amended version of S-258. S-559 was referred to the same Senate Committee as S-258.

S-573 —To provide for reporting of epileptiform seizures to the Director of Motor Vehicles by physicians and persons subject thereto. . . . Introduced on 16 February 1970 by Senator Beadleston (Monmouth). This bill which was drafted by MSNJ has, as of the 16th of March, passed in the Senate by a vote of 36-0 and was received in the Assembly.

A-802 —To include under the immunity clause of the Medical Practice Act any person who successfully completes a State Board of Medical Examiners approved course of training for certain ancillary medical services. . . . Re-introduced on 19 March 1970 by Assemblyman Ewing (Somerset) *et al.* Referred to Senate Committee on Commerce, Industry, and Professions.

Legislation to Discontinue Licensing of Chiropractors

The Council on Legislation, in conformity with the direction of the House of Delegates, early addressed itself to the drafting of legislation to accomplish the discontinuance of licensing of chiropractors in New Jersey.

On 19 October 1969 the Board approved a Council-prepared draft and ordered it circulated among component societies.

At its meeting on 5 February 1970, the Council considered and approved revisions to the original draft, submitted by the Bergen County Medical Society.

Subsequently the Bergen County Medical Society offered further proposals for the Council's consideration at its April meeting. As of this writing, therefore, the final version of the proposed legislation has not been agreed upon.

Specialty Societies

The Council on Legislation continues its established policy to invite an official representative from each specialty society to all Council meetings. Although a copy of a memorandum announcing the date of the Council's next meeting is sent to all MSNJ's Official Intermediaries with New Jersey Specialty Societies, the attendance of the representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the thinking of specialty societies concerning proposed legislation affecting the specialty fields.

Federal Legislation

At this writing there have been introduced in the Congress approximately 100 bills that would include chiropractic as an eligible service under Medicare. The significance of these measures is that the sponsors of these bills represent almost every aspect of the political spectrum and draw upon a large constituency. Apparently chiropractic is pressing to strengthen its position on the federal level. This occurrence may be attributed to the frequently expressed feeling of some legislators that since these practitioners are recognized by licensure in 48 states they should be entitled to participate in Federal Health Care Programs.

There are seven proposals for either a voluntary or compulsory national health insurance

program. These range from the AFL-CIO bill to the AMA tax credit bill. Trends indicate that several more bills on this subject matter will be introduced in spite of the fact that ranking HEW officials feel that national health insurance cannot be implemented for various reasons in the near future.

Recent HEW proposals would amend Medicare to include a "Part C" that would in effect be a prepayment health plan modeled on the Kaiser Foundation Plan.

Current State Legislation

In the afternoon of 13 January 1970, the 194th (1970) session of the New Jersey Legislature was opened. As the Legislature presently is constituted, the Senate has a total of 40 members (31 Republicans, 9 Democrats) and the Assembly has a total of 80 members (59 Republicans, 21 Democrats). By means of official legislative bulletins, the Society's official positions on all current State Legislation are regularly called to the attention of legislators as well as of component societies, cooperating agencies, county keymen, county society secretaries and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

Active support . . . all-out support for the measure

Active opposition . . . all-out opposition to the measure

Approved . . . commended as satisfactory, but not actively supported

Disapproved . . . rejected as unsatisfactory, but not actively opposed

No action . . . considered, but not regarded as significant or relevant to the proper interests of the Society

(All measures thus marked (•) are identical with bills of last year—or preceding years—and the Society's position concerning them is the same.)

•S-4 —To prohibit littering of waterways and adjacent shores and beaches and to regulate marine toilets. *APPROVED*

S-11 —To provide for a new system of work permits for minors.

A-109 —(Companion measure to S-12) *APPROVED*

S-12 —To provide for a system of identification cards and health certificates to minors over 12 years of age for use in establishing eligibility for acceptance of gainful employment. (Companion measure to S-11 and A-109) *APPROVED*

•S-19 —To require medical service corporations to pay the Commissioner of Banking and Insurance a fee of $0.02 per subscriber, member or employee covered under contracts. (Companion measure to S-20) *NO ACTION*

•S-20 —To require hospital service corporations to pay the Commissioner of Banking and Insurance a fee of $0.02 per subscriber, member or employer covered under contracts. (Companion measure to S-19) *NO ACTION*

S-27 —To repeal R.S. 2A:134-4 concerning polluting of waters used for ice harvesting. *APPROVED*

•S-102 —To authorize the Trustees of the New Jersey College of Medicine and Dentistry to acquire for their use the Jersey City Medical Center. *NO ACTION*

•S-104 —To provide penalties for first, second and third offenses of violations of the narcotics drug act. *APPROVED*

S-130 —To authorize the Department of Health to regulate the collection and disposal of solid waste. *NO ACTION*

S-163 —To authorize freeholders to close and abolish a county tuberculosis hospital upon determination that continued operation of the hospital is no longer necessary and to provide for public hearing on such resolution. *APPROVED.*

S-181 —To provide that all plans and specifications for construction or alteration of public buildings shall provide facilities for the physically handicapped and to provide for promulgation of guidelines, from time to time, by the State Board of Architects under standards of the American Standards Association, Inc. (Companion measure to S-182) *APPROVED*

S-182 —To require boards of education to provide facilities for the physically handicapped in contracts for construction and alteration of any public buildings guided by standards promulgated by the American Standards Association, Inc. (Companion measure to S-181) *APPROVED*

•S-185 —To provide that any person who advertises, sells or offers any person any compound intended for household use which contains poisonous ingredients and does not label such package clearly is a disorderly person. *APPROVED*

S-191 —To require every applicant for a motor vehicle driver's license upon first applying and every six years thereafter to submit to and pass a hearing and eye examination as shall be prescribed by the Director of Motor Vehicle. *DISAPPROVED,* although the So-

ciety approves the objective of this legislation, it disapproves this measure because of the impracticality of its implementation.

•S-194 —To provide for the licensing and registration of electrologists by the Board of Medical Examiners. *APPROVED*

•S-204 —To repeal the tax on gross receipts of unincorporated businesses. *APPROVED*

S-214 —Requires all State buildings to be provided with facilities for the physically handicapped. *APPROVED*

•S-216 —To provide for civil commitment of drug addicts. *APPROVED*

•S-221 —Prescribes the penalties for a person who sells, gives, administers, or dispenses any narcotic drug other than a medicine preparation. *APPROVED*

•S-223 —To require every district and regional board of education to appoint an advisory committee on narcotics for each of the high schools in a school district, to make studies and advise what measures should be taken to eliminate narcotics from such schools. *APPROVED*

•S-224 —To provide that no hospital or medical service corporation or insurance company shall be entitled to be subrogated to any claim of an insured as against any third party other than the employer of the insured or the employer's carrier or any hospital or physician's lien except payments made under the Workmen's Compensation Law. *DISAPPROVED,* in support of the position of Medical-Surgical Plan of New Jersey and Hospital Service Plan of New Jersey.

•S-226 —To provide for public representation on all professional boards. *ACTIVE OPPOSITION,* because professionally unqualified lay members would encumber the boards, with no appreciable advantage to the public.

•S-230 —To authorize the Board of Medical Examiners to permit municipal hospital employees who hold M.D. or D. O. degrees to practice in the hospital without a license. *DISAPPROVED,* because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in an approved training program.

•S-239 —To remove restrictions against the practice of medicine by persons in the employ of a municipal hospital who hold M.D. or D.O. degrees, and where a physician is duly licensed in any foreign country where requirements for licensing are not substantially lower than New Jersey and while teaching and not in private practice. *DISAPPROVED,* because MSNJ feels that is is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in an approved training program.

•S-240 —To restrict the availability of a patient's medical record for public use except by his consent or upon court order. *APPROVED*

•S-241 —To authorize the issuance of limited licenses to practice medicine and limited licenses as assistants in medicine. *DISAPPROVED,* as undesirable and unnecessary because interns and residents are presently not required to hold licenses as physicians and surgeons to serve in hospitals in New Jersey. No licenses should be granted to other than demonstrably qualified persons who have met the requirements of the Medical Practice Act.

•S-242 —To provide for appointment of two licensed practical nurses to the New Jersey Board of Nursing. *APPROVED*

•S-250 —To provide for the establishment of air pollution control commissions in the counties. *DISAPPROVED,* because there is no evidence that at the present time the control that is now exercised by the Department of Health is not satisfactory and that the personnel who would control these committees would be as well informed in the control of air pollution as the Department of Health. Moreover, the prevailing unified control would be jeopardized.

•S-258 —To provide for the confidentiality of information and data secured by and in possession of hospital or extended care facility utilization review committees. (Our bill) *ACTIVE SUPPORT*

•S-259 —To provide that medical records or photographic reproductions shall be retained by a hospital for seven years following the most recent discharge of a patient or until the confined persons reach age 23, whichever is later; to require retention of a discharge summary sheet for 20 years and x-ray films for five years. *APPROVED*

•S-269 —To permit the Board of Medical Examiners to grant a license for practice of medicine and surgery without further examination where an applicant shows he has been examined and licensed in a foreign country. *ACTIVE OPPOSITION,* because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes or to those of other states whose licensees New Jersey accepts on a basis of reciprocity.

•S-270 —To provide that any applicant for a license to practice medicine and surgery who, in addition to other required proofs necessary to be admitted to examination, shows he has engaged in the practice for 10 years and has reached a position of eminence in his profession shall be granted a license without further examination upon payment of the required fee. *DISAPPROVED,* because it would abrogate the present discretionary powers of the Board to act on the basis of objective evidence and would impose an ob-

ligation to make subjective judgments as to what constitutes "proof," "reputable practice," and "conceded eminence and authority in his profession."

S-293 —To provide for representation on the Board of Trustees of the Hospital Plan of New Jersey of an equal number of subscribers, physicians and public members qualified by background to act in the broad public interest. *APPROVED*

S-330 —To provide for regulation and licensing of medical care facilities and to establish a Division of Health Facilities, Service and Planning in the Department of Health. *APPROVED*

*S-362 —To define, under the Hazardous Substances Labeling and Sales Act, the term "label" as applied to an unpackaged article; the term "misbranded package" to include a child's toy and to provide a definition for "banned hazardous substance." *APPROVED*

*S-373 —To authorize the Commissioner of Health to prohibit, restrict or condition, permanently or for a specified time, any activity contributing to air pollution; to prohibit, permanently, the construction or operation of an industrial process if its contribution to air pollution would constitute an unreasonable risk and to provide for public hearing after public notice upon the proposal to exercise such power. *APPROVED*

S-374 —To authorize a governing body to prescribe penalties for violation of air pollution control ordinances but not in excess of those prescribed in Chapter 212, Laws of 1954, Section 19. *APPROVED*

*S-377 —To establish a Noise Control Act; to empower the Commissioner of Health to promulgate codes, rules and regulations for the control of noise. *APPROVED*

*S-384 —To provide for issuance of certificates for the operation of air pollution equipment or control apparatus in dwellings where such can be operated without violating any pertinent codes or regulations and if such equipment incorporates the latest advances in control technology. *APPROVED*

*S-385 —To define "area" in the Air Pollution Emergency Control Act to mean only that portion or portions of the State described in the Governor's air pollution emergency declaration. *APPROVED*

*S-386 —To authorize the Clean Air Council to establish an ad hoc joint technical committee of seven members with power to promulgate rules and regulations. *DISAPPROVED*, because there is no evidence at the present time that the control now exercised by the Department of Health is not satisfactory and that the personnel of this proposed ad hoc committee would be as well informed in the control of air pollution as is the Department of Health.

*S-388 —To exempt from the restrictive provisions of the N.J. Industrial Home Work Law those persons homebound because of advanced age, physical or mental disability, injury or illness; to provide for medical certification of ability; to establish that the N.J. Rehabilitation Commission, N.J. Commission for the Blind or other agency recommend employment; to authorize the Commissioner of Labor and Industry to promulgate rules and regulations and other amendments. *APPROVED*

S-392 —To provide that the New Jersey Agricultural Experiment Station shall institute research and investigation necessary to establish biology, breeding habits and methods of control of bloodsucking and pest insects which are a health menace. *APPROVED*

S-404 To provide that a hospital service contract to furnish services shall be for a period of one month and automatically renewed each month unless either party gives a 30-day written notice of termination. (Companion measure to S-409). *APPROVED*

*S-405 —To permit hospital service corporations to adjust premium rates based on experience rating, past or contemplated; to provide that no form of experience rating may be used until the formula has been filed with and approved by the Commission of Banking and Insurance and to require the experience rated group to be assessed a reasonable community charge. *APPROVED*

S-406 —To permit a hospital service corporation to include in its subscription contracts a provision for a lien by way of subrogation on proceeds of any payment in discharge, release, settlement, awards, etc., which the injured subscriber or dependents may have or shall assert against a third party for damages on account of injury. (Companion measure to S-408). *APPROVED*

S-407 —To permit a hospital service corporation to provide for health care services or supplies other than the services of persons licensed to practice medicine or surgery. *APPROVED*

S-408 —To authorize any hospital to enforce a lien to the full extent authorized by law notwithstanding that all or part of its charges for treatment, care and maintenance of an injured person has been or will be paid by a non-profit hospital corporation. (Companion measure to S-406) *APPROVED*

S-409 —To provide that every individual medical service contract shall provide for the payment of medical services for a period of one month from date of issue of the subscription certificate and any such contract shall be renewed automatically from month to month unless one month's prior notice is given; to provide that no contract shall be terminated in the absence of fraud or misrepresentation. (Companion measure to S-404) *APPROVED*

S-410 —To permit a medical service corporation to adjust premium rates based on experience rating, past or contemplated; to provide that no form of experience rating may be used until the formula has been filed with and approved by the Commissioner of Banking

and Insurance and to require the experience rated group to be assessed a reasonable community charge. *APPROVED*

S-411 —To permit a medical service corporation to include in its subscription contracts a provision for a lien by way of subrogation on proceeds of any payment in discharge, release, settlement, awards, etc., which the injured subscriber or dependents may have or shall assert against a third party for damages on account of injury. *APPROVED*

S-412 —To provide that any physician shall be entitled to enforce a lien filed by him to the full extent authorized by law notwithstanding that all or part of his charges for treatment, care and maintenance of an injured person has been or will be paid by a nonprofit medical service corporation. *ACTIVE SUPPORT*

S-422 —To permit a medical student to complete formal studies in the basic sciences and diagnostic medicine in three years and to require such student to serve a full year of intern training in a hospital of a medical college or one affiliated or associated with such medical college *ACTION DEFERRED* until a committee of The Medical Society of New Jersey, appointed by the Board of Trustees, obtains more information on this measure and reports its findings to the Council on Legislation

(Position subsequently changed to *APPROVED*, see Supplemental Report, page 357)

•S-436 —To provide for continuation of facilities to educate handicapped children through the summer months; to define "atypical pupils" to include those classified as handicapped and include pupils of ages 3 through 20 years. *APPROVED*

•S-463 —To provide for reimbursement for licensed chiropractors' services under any group accident, group health and group accident and health policy or contract. (See S-464) *ACTIVE OPPOSITION*

(*Note:* The position of the 1968 bill identical to S-463 of this year was one of "disapproved". It was the unanimous decision of the Council to change this position to "active opposition" in conjunction with S-464, S-465 and S-466 of this year for the reasons stated under S-464.)

•S-464 —To provide that licensed chiropractors shall have the same privileges and benefits as licensed physicians and surgeons under the act governing medical service corporations. *ACTIVE OPPOSITION*, because the services which chiropractors are licensed to provide are not among the services covered by medical service corporations. Chiropractors are not licensed or recognized as physicians or surgeons and are not qualified—or licensed —to supply medical and/or surgical services for injuries and/or disease conditions.

•S-465 —To provide for reimbursement for licensed chiropractors' services under accident and sickness insurance policies. (See S-464) *ACTIVE OPPOSITION*

•S-466 —To provide that the services of a chiropractor shall be considered medical or surgical services under the Workmen's Compensation Act, any health and accident, disability or other insurance policy or under any labor management trustee, union welfare, employee benefit or any private insurance or welfare plans. (See S-464) *ACTIVE OPPOSITION*

S-475 —To provide that no person shall sell any glue containing a solvent releasing toxic vapors or fumes which does not include an additive as required by the Commissioner of Health. *APPROVED*

SJR-5 —To establish a commission to study and evalate the effects of repeal of the Unincorporated Business Tax, Chapter 137, P.L. 1966. *APPROVED*

SJR-6 —To create a commission to study and evaluate the effectiveness of existing laws, rules and regulations relating to the practice of all branches of the healing arts dealing with any part of the mind or body of human beings. *APPROVED*

SJR-14—To extend the date for submission of the report of the Professional Board Study Commission to the Governor and the Legislature. *APPROVED*

•SR-1 —To create the "Senate Special Committee on the Training of General Practitioners of Medicine and Dentistry" to inquire into what steps the State medical and dental colleges have taken to comply with legislation to prepare students for general practice in these professions. *APPROVED*

A-6 —To provide that any person who discards an intact television tube in a place accessible to children shall be a disorderly person. *APPROVED*

•A-22 —To direct the Commission of Institutions and Agencies with the advice and assistance of the Narcotics Advisory Council to establish a program for the treatment and rehabilitation of drug addicts who are inmates of correctional institutions and to establish guidelines for use by freeholders in preparing similar programs for inmates of county jails, workhouses or penitentiaries. *NO ACTION*

•A-27 —To provide for the mandatory civil commitment of drug addicts and to establish a procedure therefor. *APPROVED*

•A-42 —To provide that alcohol in excess of 0.05% but less than 0.10% in a motor vehicle operator's blood shall not give rise to a presumption that his driving ability was or was not impaired by consumption of alcohol. *APPROVED*

•A-43 —To authorize a governing body to prescribe penalties for violation of air pollution control ordinances but not in excess of those prescribed in Chapter 212, Laws of 1954, Section 19. *APPROVED*

•A-44 —To authorize establishment of regional air pollution control districts. *APPROVED*

A-47 —To create a Division of Environment Protection in the Department of Conservation and Economic Development. *NO ACTION*

A-53 —To require persons seeking to influence legislation to identify legislation and report disbursements therewith, to file reports in such detail as the Secretary of State may prescribe, to require affidavits where no allocation of activities is possible and to prohibit employment for compensation contingent upon passage or defeat of any legislation. *NO ACTION*

*A-76 —To provide that the term "depressant or stimulant drug" shall include any hallucinogenic drug; to prohibit possession of such drugs by unauthorized persons. *APPROVED*

*A-86 —To provide that the Director of Motor Vehicles shall license an applicant upon payment of the lawful fee and receipt of a certificate issued by a teacher of an approved driver education course attesting to the applicant's ability as a driver. *DISAPPROVED* because there is no measurable evidence that the examination and licensing of motor vehicle operators under the current system is not satisfactory. Furthermore, this proposal would apparently constitute an unwarranted mandatory delegation of licensing authority to the drivers schools and would bypass the professional expertise of the Division of Motor Vehicles.

A-109 —To provide for a new system of work permits
S-11 —for minors. *APPROVED*

A-110 —To provide for a system of identification cards and health certificates to minors over 12 years of age for use in establishing eligibility for acceptance of gainful employment. *APPROVED*

*A-111 —To provide that any incorporated nonprofit association, organization, league, society or other group created to protect dumb animals shall have the same rights, powers and privileges vested in the Society for the Prevention of Cruelty to Animals. *DISAPPROVED*, because there is no evidence that existing statutes protecting dumb animals from cruelty are now being flagrantly violated or that the SPCA has failed—or is failing—to perform its responsibilities in enforcing those statutes.

*A-127 —To create an Advisory Committee on Solid Waste Collection and Disposal in the Department of Health which shall review and evaluate the effectiveness, efficiency and economy of techniques of collection and disposal of solid waste and recommend programs of research and development, including pilot projects, demonstrations and experiments for the purpose of testing and evaluating such techniques in actual working conditions. *APPROVED*

A-128 —To require every applicant for a motor vehicle driver's license, and once every 4 years therafter, to submit and pass an eye examination; to provide for designation of an official optometrist and ophthalmologist from a list of three names to be submitted by the New Jersey Optometric Association and The Medical Society of New Jersey, respectively. *DISAPPROVED*, although the Society approves the objective of this legislation, it disapproves this measure because of the impracticality of its implementation. Moreover, this bill as drawn disregards that fully licensed physicians and surgeons have a legal right to examine eyes and would discriminate against them.

*A-130 —To provide for civil commitment of drug addicts. *APPROVED*

*A-137 —To provide that abuse of a child shall include care and custody of a child by a parent or other person convicted of any crime or offense relating to use or sale of narcotic drugs and to provide a procedure for persons originating child abuse proceedings. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES*, because there is no dependable logical basis for the presumption that a parent or guardian convicted of "any crime or offense relating to the use, possession, sale, transportation or other dealing in or with narcotic drugs" would be per se guilty of child abuse. Furthermore, some of the individuals granted the right to initiate proceedings under this bill do not possess requisite educational and clinical experience to determine that the resultant injury was not accidental.

*A-163 —To empower the Governor to do all necessary things to insure that all State Departments and local political subdivisions secure full benefits available under the National Highway Safety Act and to prepare a comprehensive plan to reduce traffic accidents under the New Jersey Highway Safety Program. *APPROVED*

*A-200 —To provide for licensing, inspection and regulation of medical care facilities, to create a Commission on Hospital Care and Related Services and to provide for enforcement. *NO ACTION*

*A-217 —To require all passenger automobiles to be equipped with ventilation systems while the motor is running, effective July 1, 1971, of a type approved by the Director of Motor Vehicles. *APPROVED*

*A-232 —To include hallucinogenic drugs under the depressant or stimulant drug law; to prescribe penalties on the illegal use of LSD and other hallucinogens. *APPROVED*

*A-233 —To provide that whenever a related individual has reason to believe any person is a narcotics addict such related individual may file a petition with the county clerk requesting such person be admitted to a hospital for treatment of his addiction. *APPROVED*

*A-234 —To include in the definition of optometry one who sells, at retail, to the general public spectacles or eyeglasses containing other than plano lenses; to provide that nothing in the definition of optometry shall prohibit a duly licensed ophthalmic dispenser from providing eyeglasses as prescribed by an optometrist or physician. *DISAPPROVED*, because the vending of such glasses is not proper or exclusive to the practice of op-

tometry, whose fundamental function (under law) is to examine for defects of vision and to prescribe corrective lens. This legislation would deny to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and is discriminatory.

A-245 —To provide for closing or abolition of any county tuberculosis hospital determined by freeholders as no longer necessary. *APPROVED*

•A-251 —To provide that no hospital emergency receiving room shall be open for treatment unless there is in attendance at least one person on the staff who speaks English and is capable of interpreting same in the language of the licensed medical practitioner in charge of such room. *APPROVED*

•A-261 —To provide for commitment of convicted sex offenders; to provide for physical and mental examinations and special treatment; to provide for payment of maintenance costs by the treated person or his family. *APPROVED*

A-265 —To provide for hospitalization of any person attempting to commit suicide, to authorize apprehension of persons deemed dangerous to themselves and to repeal the statute making the attempt to commit suicide a disorderly persons offense. *APPROVED*

A-309 —To provide that where injury or death is caused by the negligence of a physician, surgeon, nurse, dentist, chiropractor, osteopath or other person rendering service under the Workmen's Compensation Law such person shall be liable at common law for any negligence. *NO ACTION*

•A-319 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

•A-358 —To authorize the Commissioner of Health to prohibit, restrict or condition, permanently or for a specified time, any activity contributing to air pollution; to prohibit, permanently, the construction or operation of an industrial process if its contribution to air pollution would constitute an unreasonable risk and to provide for public hearing after public notice upon the proposal to exercise such power. *APPROVED*

•A-360 —To prohibit thermal discharges from flowing into any waters of this State except under approved conditions. *APPROVED*

•A-367 —To create a Governor-appointed commission known as the Rutgers, South Jersey Medical and Dental College Planning Council, to choose a site for a medical-dental school in South Jersey. *ACTIVE SUPPORT*

•A-368 —To establish a Noise Control Act; to empower the Commissioner of Health to promulgate codes, rules and regulations for the control of noise. *APPROVED*

A-383 —To provide that the course in health in public schools shall include instruction in the study of nutrition and the selection and preparation of food for personal and family consumption. *APPROVED*

•A-405 —To establish a Division of Medical Care Facilities within the Department of Health which shall have comprehensive responsibility for the development and administration of the State policy with respect to hospital and related medical care services in all public and private institutions and to provide that the board of directors of hospital service corporations shall be composed of an equal number of representatives of hospitals, subscribers, and the general public. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because it poses a threat to the free practice of medicine and the continued life of the Medical-Surgical Plan of New Jersey.

•A-415 —To provide that the State Sanitary Code may contain regulation on the collection and disposal of solid waste and to provide that the State Department of Health shall supervise sewage treatment or solid waste collection and disposal facilities. *APPROVED*

A-428 —To require any person applying for a motor vehicle license to accompany his application with a doctor's certificate certifying that he is not an alcoholic. *DISAPPROVED,* because there is no way a physician can certify that an individual is not an alcoholic.

•A-429 —To define a "depressant or stimulant drug" to include any hallucinogenic drug, including d-lysergic acid diethylamide (LSD), n-n-dimethyltryptamine (DMT), psilocybia, mescaline, peyote, bufotenin, epena, parua, ayahuasca, yage, caapi, amaneta, muscaria and other substances and to provide penalties. *APPROVED*

A-448 —To provide that the phrase "substance containing any chemical material having the property of releasing toxic vapors or fumes" shall mean and include but not be limited to any glue, cement, adhesive, paint remover or other chemical compound. *APPROVED*

•A-494 —To require disclosure of generic and brand names on drug compounds and medicines. *APPROVED*

•A-525 —To provide that unauthorized persons who practice medicine or surgery without first having obtained a license are disorderly persons. *DISAPPROVED,* because sanctions of existing law are adequate to protect the public against the unauthorized practice of medicine and surgery or any violation of the Medical Practice Act. Moreover, many of the provisions of present law deal with technicalities the violation of which should not warrant the stigmatization of the offender as a disorderly person.

•A-555 —To provide for determination of potable water standards by the Department of Health; to provide for hearings prior to adoption of such standards; to prohibit construction of any new water supply system, pumping station or water stoppage facility

until the sanitary engineering features of plans and specifications have been reviewed and to provide for supervision of all water supply systems with respect to quality, protection and maintenance of adequate volume. *APPROVED*

*A-557 —To permit the Department of Health to exempt incinerators which by type and size, in their opinion, should not be subject to the licensing requirements of the solid waste disposal act. *APPROVED*

*A-576 —To provide that the Commissioner of Institutions and Agencies shall not issue a certificate of approval for operation of narcotics treatment centers unless he is satisfied that proper care complying with standards can be performed and to provide that the State Board of Control of the Department of Institutions and Agencies shall adopt, promulgate and enforce such other rules and regulations deemed necessary. *NO ACTION*

Aproved (page 433)

Supplemental Report

At its meeting on 19 April, the Board of Trustees considered and acted upon recommendations from the Council's meeting of 9 April. The Council therefore offers this Supplmental Report #1 covering items dealt with since the compilation of its annual report.

Legislation To Discontinue Licensing Of Chiropractors

The Council considered proposals from the Bergen County Medical Society to eliminate the future licensing of chiropractors. These proposals Bergen County felt would be more favorably received by the Legislature than the draft of legislation presently approved by the Board of Trustees of The Medical Society of New Jersey for introduction. The Council was of the opinion that the proposals incorporated in Bergen County's suggestions instead of eliminating the future licensing of chiropractors might effect an elevation of the standards of chiropractors in such a way as to eventuate in the granting of plenary licenses to chiropractors as physicians and surgeons in New Jersey.

As a result, the Council recommended and the Board approved that an Ad Hoc Committee be appointed to develop solutions that would not only achieve the result desired but would also be conducive to favorable legislative action. This Committee would have the right to call upon anyone it feels would be helpful in advising in the drafting of proposed legislation on the banning of chiropractors in New Jersey. The members of the Ad Hoc Committee are: Henry J. Mineur, M.D., Meyer L. Abrams, M.D. and James S. Todd, M.D.

Current State Legislation

The following list presents the official position of MSNJ regarding additional bills currently in the Legislature. Those measures thus marked (*) are identical with bills of last year—or preceding years—and the Society's official position concerning them is the same.

S-422—To permit a medical student to complete his medical training in three years, at which time he would receive a degree of Bachelor of Medicine, and then be required to spend a fourth year in intern training in a hospital either attached to or affiliated with a medical college, following which he would be awarded the degree of Doctor of Medicine and be eligible to take the State Board Examination. *APPROVED*

*S-542—To provide that the need for a certificate under the act providing for certification of x-ray technicians shall not apply to a licensed dentist who operates only x-ray equipment for dental radiographs under the direct supervision of a licensed dentist and to provide for 9 examiners, in place of 10, on the x-ray technician board. *APPROVED*

S-559—To provide for the confidentiality of information and data secured by and in the possession of utilization review committees established by hospitals, extended care facilities, skilled nursing homes, or other health care service facilities. (Amended version of S-258 of this year which MSNJ actively supports . . . Our bill) *ACTIVE SUPPORT*

S-569—To establish a Children's Risk Register in the Department of Health for handicapped and high risk children to be used for their care, treatment, education and rehabilitation. *DISAPPROVED*, because it would be impractical of implementation because of its broad application and furthermore might lead to the

stigmatization of a potentially handicapped child and might also cause a great deal of undue anxiety in some parents.

S-573—To provide for reporting of epileptiform seizures to the Director of Motor Vehicles by physicians and persons subject thereto. (Our bill) *ACTIVE SUPPORT*

S-574—To authorize counties and municipalities to make appropriations for the treatment and training of emotionally maladjusted or physically undernourished children between the ages of 5 and 12 years. *NO ACTION*

S-624—To provide for establishment of regional evaluation centers for mentally retarded, physically handicapped, emotionally disturbed, socially maladjusted and multiple-handicapped children. *DISAPPROVED*, because there is no evidence that present procedures and facilities are not adequate.

S-630—To establish a Department of Environmental Control in the Executive Branch of government. *NO ACTION*

*S-636—To provide that the State Sanitary Code shall not contain any regulation which requires or directs the mandatory fluoridation of any public potable water supply. *APPROVED*

S-666—To authorize the Governor to convene a Governor's Conference on Food, Nutrition and Health. *NO ACTION*

*S-671—To provide that grounds for refusal to grant, suspend, or revoke licenses to practice medicine, surgery or chiropractic shall include violations of any rule, regulation or code of ethics promulgated by the Board of Medical Examiners or where a practitioner is found guilty of unprofessional, dishonorable or unethical conduct. *DISAPPROVED*, because it is the proper function of the State Board of Medical Examiners to enforce the rules and laws governing the practice of medicine, and it is the province of the profession of medicine itself to enforce conformity with principles of ethics and standards of professional conduct.

S-674—To revise and repeal various statutory provisions to conform them to P.L. 1967, Chapter 254, which abolished county offices of coroners and county physicians. *APPROVED*

S-676—To grant immunity from liability, civil or criminal, to any physician, nurse, or hospital for any act or omission in the course of taking a breath sample at the request of a police officer. *APPROVED*

S-688—To provide for contents of certificate of birth established by the State registrar for adopted children and to assign to the adopted person the family name of the adopting parents. *APPROVED*

S-691—To provide for reimbursement of psychologist's services under any accident health or accident and health insurance. *DISAPPROVED*, as unnecessary . . . since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

S-692—To provide that service of a psychologist shall be deemed to be within the provisions of the Act concerning Medical Service Corporations. *DISAPPROVED*, as unnecessary . . . since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

S-700—To permit the Interstate Sanitation Commission under the Tri-State Compact to develop, after public hearing, and place in force classification of waters and effluent standards within the District. *APPROVED*

S-732—To provide that a violator of the motor vehicle laws shall be first advised that his refusal to submit to a breath test sample may subject him to revocation of his license for six months. *APPROVED*

S-745—To establish the Solid Waste Management Act and to create an Advisory Council on Solid Waste Management in the Department of Environmental Protection. *NO ACTION*

S-746—To authorize the Public Utility Commission to regulate the collection and disposal of solid waste under the "Solid Waste Utility Control Act." *NO ACTION*

A-273—To provide for a Second Injury Fund under the Workmen's Compensation Law; to require the State, county, municipality, district or public agency to make contributions thereto. *APPROVED*

A-506—To eliminate the requirement of a medical examiner's investigation in death cases occurring within 24 hours after admission to a hospital or institution and to eliminate the need for personal presence of the Medical Examiner, his deputy or assistant at the scene of the death requiring investigation. *APPROVED*

*A-518—To repeal the gross receipts excise tax on unincorporated businesses. *APPROVED*

A-589—To permit the superintendent of State Police to appoint physicians and other medical personnel to his staff as required. *APPROVED*

A-593—To require each migrant labor camp to provide for a water-carried sewage disposal system no later than November 1, 1970, in place of January 1. *APPROVED*

A-595—To increase penalties for violations of the narcotic drugs act. *APPROVED*

*A-600—To require ophthalmic dispensers to hold a high school diploma or equivalent in order to qualify for examination and certification. *APPROVED*

A-603—To provide for placing of persons on a permanent absentee voting list upon certification of a physician attesting to permanency of confinement due to illness or physical ability; to provide for mailing of such absentee ballots not less than eight days before each election by certified mail. *APPROVED*

A-620—To provide that the board of education shall require all school children to be immunized against poliomyelitis, measles and rubella disease and to permit such at public expense.

DISAPPROVED, because we favor A-639 which is permissive legislation. A-620 would abrogate the discretionary powers of the boards of education.

A-621—To require all school bus seats to be equipped with seat safety belts of a type approved by the Director of Motor Vehicles. *NO ACTION*

A-639—To provide that the board of education may require immunization of school children against rubella. (See A-620) *APPROVED*

A-656—To provide for "occupational hearing loss" under the Workmen's Compensation Law. *APPROVED*

A-667—To require all law enforcement officers to determine if any person found in an unconscious state is wearing an identificatian tag indicating he is an epileptic or diabetic. *APPROVED*

A-694—To provide penalties for operation of a motor vehicle while under the influence of hallucinogenic drugs. *APPROVED*

A-695—To authorize the Director of Motor Vehicles to refuse to license or to revoke the license of a chronic alcoholic. *DISAPPROVED,* because there is no definition of "chronic alcoholic" nor are there standards or guidelines to determine who may or may not be a chronic alcoholic.

•A-706—To provide that nothing in the Workmen's Compensation Law shall be construed to render immune from liability (under the common law or otherwise) on account of injury or death, any person who, at the time of the injury or death, was in the employment of the same employer as the person injured or killed and who engaged in the practice of medicine, surgery, dentistry or chiropractic. *APPROVED*

A-726—To create an "Environmental Quality Council" in the office of the Governor. *NO ACTION*

A-730—To make the bringing of narcotic drugs or marihuana illegally into the State a misdemeanor. *APPROVED*

(*Note*: By action of the Board the position of "No Action," recommended by the Council, was changed to that of "Approved.")

A-744—To provide for the medical examination of school pupils who may be under the influence of narcotic, depressant, or stimulant drugs or any chemical or chemical compound. *APPROVED*

A-752—To create a Board of Hearing Aid Dispensers. *APPROVED*

A-762—To provide for legal abortions. *DISAPPROVED,* in that it exceeds the policy recommendations adopted by the 1968 House of Delegates of MSNJ in that it would permit an abortion on an unmarried woman, "provided that the pregnancy commenced while she was under the age of 16 years and is still unmarried at the time the abortion is performed."

Amendment by the House to change position of MSNJ on A-762 to that of APPROVED (page 433)

A-763—To provide that the Board of Medical Examiners may refuse or revoke a midwifery license for termination of human pregnancy. (Companion measure to A-764.) *DISAPPROVED,* because the key phrase in the amendment used is much too broad. The birth of a child is itself a "termination of human pregnancy" and certainly that should not be considered grounds for revocation of a midwifery license.

A-764—To provide that the Board of Medical Examiners may refuse or revoke a physician's license for his failure to respect the limits set by State laws governing termination of pregnancy. (Companion measure to A-763.) *APPROVED*

A-776—To prohibit deposit of human body wastes on lands within the State and to regulate railroad toilets. *APPROVED*

A-794—To increase the penalty for pollution of potable waters to not more than $500 for the first violation and no more than $2,500 for subsequent violations, each day in place of week being a separate violation, and to permit any agency supplying potable water to institute action against polluters. *NO ACTION*

A-795—To prohibit the dumping of industrial waste into any of the waters of this State except under conditions approved by the Department of Conservation and Economic Development. *APPROVED*

A-802—To include under the immunity section of the Medical Practice Act any person who successfully completes a State Board of Medical Examiners approved course of training for certain ancillary medical services. (Our bill.) *ACTIVE SUPPORT*

A-828—To permit the Public Utilities Commission to require any public utility to furnish service which tends to conserve and preserve quality of environment and prevents pollution of water, land and air. *APPROVED*

A-834—To provide for eye examinations of every child enrolled in the kindergarten class. *DISAPPROVED,* because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or a physician licensed to practice medicine in the State of New Jersey would, in consequence, be an unjustifiable and expensive redundancy.

A-839—To authorize the Commissioner of Health to provide for residential care and treatment for drug addicts in existing non-State facilities. *NO ACTION*

A-840—To authorize the Department of Institutions and Agencies to provide for residential care and treatment of mental patients in existing non-State facilities. *APPROVED*

A-850—To provide that the Department of Education shall supply each school district with sufficient guidelines for teaching the effects of narcotics and depressant and stimulant drugs. *APPROVED*

*A-852—To provide that no dog or other animal caught or procured shall be made available for purposes of experimentation. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

A-854—To remove "Class X narcotic drugs" from exempt status under R.S. 24:18-7 concerning pharmacy prescriptions. *DISAPPROVED*, because although we recognize the danger in the abuse of these medications by youths the requirement of a physician's prescription for an adult purchaser creates an unwarranted expense with no appreciable equal benefit to the general public.

A-872—To provide that any person not a narcotic addict who sells, gives, administers or dispenses any hard drugs to a person over 16 years of age shall be guilty of a high misdemeanor and sentenced for life and upon a second conviction or if selling to a person under age 16 shall be guilty of a high misdemeanor and sentenced for life with no parole. *APPROVED*

A-877—To require labeling of food where appropriate "This article of food was frozen and permitted to thaw." *NO ACTION*

*A-879—To require the licensing of persons who carry on the practice of medical technology and to create a Medical Technology Advisory Committee. *DISAPPROVED*, because there is currently in New Jersey and across the nation a serious ancillary personnel manpower shortage. This bill would serve to aggravate and intensify the dearth of qualified personnel and would thus have an untoward effect upon the delivery of quality health care.

A-880—To provide for an additional member to the State Board of Medical Examiners. *DISAPPROVED*, since the addition to the State Board of Medical Examiners of an individual expert in the licensing of medical technologists would be of no appreciable significance in view of our disapproval of A-879.

A-887—To reorganize the Department of Conservation and Economic Development as the Department of Environmental Protection and to establish therein the Divisions of Natural Resources, Fish, Game and Shell Fisheries, Water Policy and Supply and Parks, Forestry and Recreation. *APPROVED*

Approved as amended—A-762 (page 433)

Administrative Council

Medical Services

Louis K. Collins, M.D., Chairman, Glassboro

(Reference Committee "E")

Once again the Council focused its efforts on matters relevant to the maintenance and advancement of the standards and character of medical practice in New Jersey. The following report will give in detail the work of the Council during the past year.

Utilization Review Committees

The Board of Trustees charged the Council on Medical Services with the assignment of preparing guidelines for utilization review committees under Medicare and Medicaid. Accordingly, a compilation of the Council members' opinions was completed and transmitted to the Board for consideration at its April meeting.

Approved with notation (page 433)

San Joaquin Medical Foundation

We discussed a report on the Foundation for Medical Care of San Joaquin, California, and although recognizing the excellence of the program, concluded that it would be highly impractical to attempt to implement a similar program on a statewide basis in New Jersey.

Joint Medicare Claims Inquiry Committee

The Council is pleased to note the establishment of the aforementioned committee by the Board of Trustees. It is by this means that physicians who feel their fees have been arbitrarily reduced, or who have other bases of dissatisfaction with the Medicare program have a medium for submission of complaints.

Medicaid Negotiating Committee

Frequent meetings have been held with State Officials to arrive at a basis of compensation for services rendered that will not only induce the participation of all members but also result in a fair and equitable disbursement of State tax monies. The latitude of both parties however is somewhat restricted by Federal laws and regulations. Our efforts in this area will continue and intensify in the future.

Hospital and Extended Care Facility Benefits Under Medicare

The Council is dissatisfied with several incidents where payments were disallowed to Medicare patients subsequent to discharge from the hospital or extended care facility to the financial detriment of the patient involved. The Council recommended to the Board of Trustees:

That MSNJ record itself as opposed to the retroactive denial of hospital and extended care facility benefits under Medicare, and urge that all cut-off dates for payments be announced prior to the effective date of cessation.

The Board adopted this recommendation and has initiated steps to adjust the situation.

Fee Inequities Under Medicare and Medicaid

Because of the fee profiles currently in use, older physicians find themselves locked in by fees over which they have no control, whereas the younger physician without a fee profile can charge higher fees without repercussions. There should be a means by which fees can be adjusted to meet increasing costs.

Recommendation

That the Society put itself on record with all third-party payors under health care programs concerning its dissatisfaction with the present circumstance which freezes the fees of all physicians as of a past date and leaves no channel open for facile and equitable adjustment of those fees to cover increased costs of procedures in practice and the general increases in the cost of living.

(This recommendation was previously approved by the Board of Trustees and no further action was necessary.)

Relative Value Index

In compliance with the directive from the 1969 House of Delegates to update the Proposed Relative Value Index of 1960, the Council sent relevant sections of the index to the appropriate specialty societies for their comments and/or revisions. The response thus far has been disappointingly slow, and the Council is not in a position to have available for consideration by the 1970 House of Delegates an updated version of the Proposed Relative Value Index of 1960.

Recommendation

a) That, inasmuch as MSNJ's proposed 1960 Relative Value Index was basically derived from the 1957 edition of the Relative Value Study prepared by the California Medical Association, the 1970 House of Delegates of The Medical Society of New Jersey either authorize the adoption of the fourth edition of the California Index (in the form utilized immediately prior to the publication of the latest Edition) with any necessary updating or revisions as required, or

Approved (page 433)

b) Reaffirm its original mandate that MSNJ's Proposed Index of 1960 be updated, which task could not be completed for several months.

No action necessary in view of approval of (a) above (page 433)

In view of the fact that the Fourth Edition of the California Index is presently accepted and in common usage throughout the country and in New Jersey, the Council is unanimous in supporting the first alternative, namely, the adoption of the Fourth Edition of the California Index.

Approved (page 433)

Special Committee to Council on Medical Services

Occupational Health, Workmen's Compensation, and Rehabilitation

Joseph A. Lepree, M.D., Chairman, Elizabeth
(Reference Committee "E")

Physicians Under Workmen's Compensation —Usual and Customary Fees

It was noted that the State of New Jersey should pay usual and customary fees to treating physicians, but that for some inexplicable reason this has not been the policy. It was then pointed out that there is a New Jersey Workmen's Compensation Law Study Commission which is evaluating the Workmen's Compensation Law in New Jersey and suggesting amendments, or repeal thereof and substitute legislation. To this end, the Committee recommended that:

The Board of Trustees, apprised of the situation as it exists, be requested to issue a letter to the Governor requesting adequate representation of the medical profession on the New Jersey Compensation Law Study Commission.

The Board concurred, and subsequently sent a letter to the Governor. A reply was received from the Governor thanking MSNJ for its concern in this matter. The Governor went on to say that the Workmen's Compensation Law Study Commission has already completed its work and filed its report. (A copy of the report was enclosed.) The Governor further stated that although the work of the Commission has been completed, this is in no way an indication that this matter is closed, and that he would deeply appreciate further recommendations for revision of the present statutes.

Rehabilitation Services

Once again emphasis was placed on the fact that many of the resources available in New Jersey for rehabilitation purposes are not being fully utilized. It was resolved by the Committee that the quickest and most efficient source of information of available services is the social service worker in the hospital who could direct the patient to the proper rehabilitation agency. The Committee acknowledges with appreciation the efforts of Dr. Jarvis Smith and the State Rehabilitation Commission in submitting periodical listings of Rehabilitation Service Offices in *The Journal* for the information of the membership.

The Committee decided to present exhibits in three categories at the meeting of MSNJ at Atlantic City in May 1970. The exhibits will be broken down as follows:

1. Exhibit by the New Jersey Rehabilitation Commission
2. Exhibit on Workmen's Compensation
3. Exhibit on Occupational Health

Current New Jersey law, instability of the Second Injury Fund, inherent prejudice in some industries, and employment policies giving priorities to certain classes of the population, all contribute to the difficulty in placing the disabled in gainful employment. Until such time as New Jersey law is changed, and the various political and social pressures have been eased, the employment market for the disabled will remain restricted, and the Committee does not in the near future anticipate any significant change.

Social Security Benefits

It has been noted by the Committee that when a person is totally disabled for six months, he is eligible for disability benefits under Social Security. The individual may then return to work for a period of one year and continue to collect disability benefits. After the one year (trial period) if he is able to continue to work, his disability benefits will be discontinued. This is to encourage the disabled to return to work without fear of jeopardizing their Social Security benefits, and all patients in this category should be urged to utilize these liberalized benefits in the law.

Approved (page 433)

Administrative Council

Mental Health

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "F")

The Council's primary goal this year has been the further pursuit of the proposal that it initiated last May, at the 203rd Meeting of the House of Delegates, in respect to petitioning the Governor to inaugurate a study of the State Mental Health Program. Since the State of New Jersey signed a contract with the American Psychiatric Association in November of 1969, to support a 16-month survey of the State's Mental Health Programs, the Council has been actively involved in drafting a position statement to incorporate the numerous deficiencies well known to the members of this Council. Individual members of the Council have appeared in various sections of the State at public hearings of the survey teams in order to voice their individual ideas as well as to attend the final public hearing on April 2 in Trenton when the survey team completed its hearings. Although the majority of the Council members has supported the contention that there should be a separate Department of Mental Health with direct access to the Governor, as well as medical responsibilities of the Mental Health Services of New Jersey, this statement was found to be in contravention to the action of the House of Delegates taken in 1968 when it disapproved Resolution No. 14, and again in 1969 when it deleted recommendation (a) of this Council's report. As a consequence, the Council has been vigorously involved in endeavoring to draft a new statement that will receive the approval of the Board of Trustees by the time of our Annual Meeting.

Although the reports of the special committees of our Council are listed below, significant items of each bear reiteration at this time.

The Committee on Alcoholism has not been active throughout this year and the appointed Chairman has suggested that the committee be reassigned to a new chairman for the ensuing year, with the feeling that those items in the area of alcoholism which the Council of Mental Health has consistently felt require the action of the Medical Society could gain new impetus.

The Special Committee on Drug Abuse has primarily concerned itself with the methadone treatment for the management of the hard-core addicts, urging its support throughout the State facilities.

The Special Committee on Emotional Disorders of Childhood and Adolescence has been one of the busiest and most active of all the special committees. It succeeded in finalizing for publication its white paper on dyslexia and has also pursued its investigation of the special educational facilities within the State for emotionally retarded and mentally ill children and adolescents.

The Special Committee on Mental Retardation has prepared a scientific exhibit for display at the Annual Meeting and has inaugurated conferences with the State Department of Education in the hope of enlarging upon the Beadleston Act and of obtaining additional legislation that will further accomplish its goals.

The Special Committee on Seizures has also been actively involved in endeavoring to provide new legislation that will more carefully define the area of seizures as well as to resolve the conflict between physicians and departments of the State requiring the reporting of all conditions "within the realm of seizures." Further, they have occupied themselves in the preparation of an exhibit at the Annual Meeting this Spring.

The Board of Trustees authorized the Chairman of the Council to attend the 16th Annual

Conference of State Mental Health Representatives, held by the A.M.A. Council on Mental Health, March 13 and 14, in Chicago. The program was to be on Mental Health Programs for the poor. Because of a conflict the Chairman was unable to attend and designated Dr. Evelyn Ivey to act in his behalf. A report of her observations at the Annual Conference will be forthcoming.

Our Council this year has played a prominent role in instigating the survey by the American Psychiatric Association into the mental health facilities of the State. It is quite evident that because of the depth of the survey, this program will carry through the following year. We are fully aware that there will remain a multitude of recommendations that undoubtedly will fall within the realm and scope of this Council, and as a consequence the members anticipate that it will remain for them to be actively involved in promoting these recommendations so that the full realization of a comprehensive mental health program for the citizens of New Jersey can be accomplished within the confines of our State.

Approved (page 438)

Special Committees to Council on Mental Health

Alcoholism

Henry J. Mineur, M.D., Chairman, Cranford

(Reference Committee "F")

No business was referred to the Committee. Consequently, no meetings were held during this administrative year.

Approved with notations (page 438)

Drug Abuse

Henry A. Davidson, M.D., Chairman, East Orange

(Reference Committee "F")

The year closing has been a period of fright, almost panic, on the problem of drug abuse. Until this year, we could comfort ourselves with the thought that there were two kinds of addiction: enslavement by heroin and other opium derivatives; and abuse of marijuana and other "soft" drugs. We assumed that heroin was a vice of poor people who lived in the slums and therefore did not touch our personal lives. However, there is now evidence that heroin has invaded suburban high schools and is beginning to become the drug of preference among middle class and upper class adolescents. So parents and school administrators are now turning to us and saying: "What can we do?" It is no longer a problem that afflicts some distant mid-city slum. The tide is coming perilously close to our own door steps.

As a profession, we have not played a particularly brilliant role in understanding drug

abuse. Most of the self-help groups, for example, have little medical supervision or participation. This somewhat parallels the early experience of Alcoholics Anonymous, who had felt that physicians just weren't interested in the alcoholic. Law enforcement people have had much more to say about drug abuse than physicians. Religious leaders have also involved themselves, most of them with the over-simple explanation that drug abuse is due to weakened family discipline or lack of religious training.

Apparently what is happening is that the American public has been sold on the idea that there is a source of happiness in pills. Every evening on television commercials, we see how anodynes, sedatives, stimulants, hypnotics and antacids can be swallowed with great benefit. The average middle-class home in America has a row of bottles and vials in every bathroom closet, where, standing in array, is a collection of pills, tablets, and capsules to assure sleep, neutralize hangovers, calm the nerves, relieve tension, conquer headaches, and cure acid indigestion. Thus, in our middle-class suburban culture, there has developed the idea that it is all right to keep taking pills. And when mother and father do keep swallowing pills and drinking cocktails every day, it is hard to tell the adolescent that this is all wrong. Many of the pillheads among the parent population got that way by swallowing prescribed tablets and capsules. It has practically become a "doctor-recommended" way of life. Most of us don't think hard enough about the effects of handing out renewable prescriptions for 100 tablets or capsules each. Sometimes we don't count the frequency of renewals. To renew the 100 capsules every fortnight is to permit the patient to swallow seven a day.

Your Committee on Drug Abuse is, of course, concerned about the doctor's role here at both ends of the problem; the physician's responsibility in handing out these prescriptions so freely, and the physician's responsibility for participating in control programs. In 1970, the Editor of *The Journal* has been most cooperative with the Chairman of this Committee and in the March issue alone has published an item from the New Jersey College of Medicine and Dentistry, an editorial on the "drug pandemic" and a useful monograph by Doctor Freymuth on the position of methadone in drug abuse control. The New Jersey College has seriously taken on the burden of physician-responsibility in this field—both in terms of direct service to addicts, and in teaching professional personnel and the public about the problem.

We commend the Division of Drug Abuse within the College's Department of Public Health, and urge that Rutgers Medical School set up a similar program. We think it will be a mistake if the problem escapes from medical supervision and becomes a matter of control by police officials, social workers, psychologists, clergymen, and reformed addicts. All these people have important roles to play, but a medically centered program is still the desideratum.

The physician has several specific functions here. He can interest himself in the methadone program by using this for detoxification, and then by working with those doctors authorized to supervise methadone maintenance. We realize that methadone is not a panacea, but at the moment it does offer promise and is one of the few positive steps we can take. We urge physicians to be cautious about prescribing sedatives, hypnotics, tranquilizers, mood stimulators and other psychotropic drugs—especially cautious about unsupervised renewals. This not only may lead to the addiction of the patient, (in both emotional and physiologic senses) but may also serve in effect, to give "permission" to adolescents, or at least to furnish them with a bad example. We urge physicians to interest themselves in the medical school programs. We realize that there is now a confusing medley of self-help organizations, group therapy units, clinics, halfway houses, treatment centers and therapeutic communities all working in the same field, and suggest that we offer these units medical consultation and supervision facilities. So much of the effectiveness of these programs depends on local participation, that no

state-wide policy will do. However, in every county where there is a drug abuse problem of any size, the county medical society should have a small and active drug abuse committee. The medical profession has played a praiseworthy role in the control of epidemics and pandemics in the past. It is hoped it will not let this one go by default.

Approved (page 438)

Supplemental Report

In view of the rapidly rising interest in the doctor's role in drug abuse, your special committee suggests that the House of Delegates adopt the following position paper.

Drug abuse is a public health problem with many sociologic and psychologic overtones. As doctors of medicine we are concerned in terms of individual counseling of our own patients, in our responsibility for many aspects of public health, and of course in the direct medical management of acute and chronic toxic reactions. On the other hand, there are serious limitations on what our profession *can* do. Many phases of drug abuse are beyond our jurisdiction and control. Most drugs in the category of LSD, heroin and marijuana, are delivered to the abuser through illegal channels, not through physician-written prescriptions, and—apart from treating acute intoxication—these important drugs are beyond our reach as physicians. We are living in a drug-oriented society. Radio and television advertisements give the impression that a drug is available to give happy relief for acid indigestion, hemorrhoids, nervous tension headaches, ruffled nerves, joint pains, and insomnia. Our profession, of course, is not responsible for the writing and broadcasting of such claims and we are in no position to stop them. All this has contributed to the public's expectation of instant happiness available at the supermarket. Attention is also called to the fact that drug abusers, (including alcoholics) do not ordinarily go to the physician for help unless they are in trouble. We cannot treat people who don't come to us, and we certainly do not recommend legal compulsion of visits to the doctor. Thus we enter a *caveat* to the thought that, by ourselves, we of the medical profession can control this problem.

However, there *are* some things we *can* do. Some drug abusers—especially those taking barbiturates, sleeping capsules, amphetamines and pain-relievers were first introduced to their drugs through a physician's prescription. We call on the doctors of New Jersey to avoid prescribing abusable drugs for purposes other than medical treatment. For example, amphetamine is a widely abused drug, and physicians are urged not to prescribe amphetamine simply for weight loss, especially in adolescents. In general, mood-influencing medications should be prescribed with caution. Indeed, some medications not ordinarily thought of as behavior-modifiers (cortisone type drugs, for instance) may have an effect on mood, and patients may become habituated to them. The doctor should be wary of the patient who comes into his office, specifically naming the medicine he wants, who asserts that such and such medication had helped him in the past. Tranquilizers and mood-elevators are powerful drugs with potential for abuse or habituation and should not be prescribed casually. Some tranquilizers and depressants may be used with suicidal intent. The doctor who indicates how many tablets or capsules should be dispensed should remember this. If a patient is already depressed, the physician should think twice before prescribing a tranquilizer. These drugs are, after all, sedatives, and depressed patients do not usually need any additional sedation. As every doctor should know, certain drugs have paradoxical effects and the careful physicians weighs this, too.

Many medicine chests in private apartments and homes contain bottles of sedatives, hypnotics, cold remedies (which often have antihistaminic or mood-changing effects) and

tranquilizers. Most of these do result from physicians' prescriptions or advice. To some extent, the young people who experiment with drugs can say that they learned of the value of drugs by watching the way their fathers and mothers depend on capsules and tablets.

A prescription is a precious document, a passport to health not to abuse. Specifically, the doctor should never hand out a prescription without writing down the limits on its refill. The prescription should specify the earliest date of refill as well as the number of refills. To prescribe a bottle of 100 capsules with a note to refill only twice is not enough. If the doctor says "2 tablets a night" the prescription should not be filled before 6 weeks have gone by. The patient who brings the empty bottle back to the pharmacy after two weeks, is obviously taking 6 or 7 a day and the refill should be prevented by a note indicating the earliest refill date. Quantities should be written in script as well as in numerals. The prescription which reads *50 tablets* is too easily altered to read 150. The word "fifty" should be spelled out. The total quantity must be kept small enough to prevent the patient from tripling the dose recommendation or to prevent him from selling his surplus to other drug abusers. The patient would not be an addict if he could handle the medication himself.

We suggest that a committee of this Society meet with a committee of the New Jersey Pharmaceutical Association to see if we can work out some kind of code for pharmacists too. The pharmacist should be sensitized to the danger of dispensing hundreds of capsules or tablets to any patient, and should check with the doctor by telephone before dispensing such large quantities. Perhaps this committee should talk with the State Board of Pharmacy about adopting official guidelines here.

Self-help groups have burgeoned over the last few years, and in New Jersey alone there are at least a half dozen such groups, some operated completely by ex-addicts. In general these are worthwhile enterprises, since pressure from their peers—other drug users and ex-addicts—can be more effective than sermons from their health counselors. However, these groups need medical advice, and physicians should make themselves available for such advisory duties. Indeed, the time may have come when the state should license all such self-help groups, and their centers, residences, homes and the like. And perhaps some degree of medical supervision should be a prerequisite to such licensing.

It is suggested that appropriate committees from both The Medical Society of New Jersey and our New Jersey Pharmaceutical Association be assigned to draw up a catalogue or list of commonly prescribed drugs that can influence mood, or drugs that have an easy potential for abuse; and that doctors be advised to put limits on their own prescription of, and pharmacists be urged to double-check on the dispensing of all drugs on this list.

By direct education as to the effect of drugs, we may be able to keep people from moving into the drug scene, an education delivered in a simple matter-of-fact way without hysteria, without exaggerating the evil effects, without recommending brutal or harsh punishments. This kind of education is a legitimate function of the doctor of medicine. And we can strengthen the campaign to prevent drug abuse by taking the simple precautions here suggested in the prescribing of all drugs.

Approved (page 438)

Learning Disorders In Children

Dextro-amphetamine in dosages of 10 to 25 milligrams a day proved helpful in correcting some learning disorders of children. Intelligence test scores were not raised, nor was undue motor activity inhibited, but improvement was noticed in visual perception and rote learning.

—C. K. Connors, *et al.* AMA *Archives of General Psychiatry*, 21:182 (August 1969)

Emotional Disorders of Childhood and Adolescence

Eugene V. Resnick, M.D., Chairman, Paramus

(Reference Committee "F")

In the five meetings held by the Committee during the past year, attention was focused on New Jersey facilities for the special education of emotionally and mentally ill children and adolescents. The Committee's interest in this area was derived from its conviction that the availability and quality of these facilities usually play an important part in determining the outcome of illness in these youngsters, and that often the patient's educational program is involved intimately with his psychiatric treatment. The Committee communicated by mail with all twenty-one of the County Superintendents of Schools and with the Directors of the Children's Division of each of the six state hospitals. In-person conferences were held with several of the County Superintendents and with the Director of the Bureau of Special Education and Pupil Personnel Services of the State Department of Education. It was evident that there are many inadequacies in available educational facilities for mentally and emotionally ill children, often working to the detriment of their treatment. Apparently, there are instances of youngsters whose stay in a state hospital is prolonged because of the inadequacy or unavailability of facilities in their home community. The Committee is exploring with the State Department of Education means of improving this situation.

Other areas of interest to the Committee have been the problem of lack of Blus Cross coverage for partial hospitalization programs for youngsters, suggested revisions of the proposed Relative Value Index for those procedures involving psychiatric treatment of children and adolescents, and distribution of the statement on Dyslexia to interested organizations.

Committee members were represented on a seminar held on physical education for the exceptional child and on the Child Health Advisory Committee of the New Jersey State Department of Institutions and Agencies.

Approved (page 438)

Mental Retardation

Miles E. Drake, M.D., Chairman, Vineland

(Reference Committee "F")

The Committee prepared and presented a scientific exhibit at the 1969 Annual Meeting. This was designed to present the latest available information on the chromosomal and inborn errors in metabolism, with some emphasis being placed on aminocentesis at 16 to 18 weeks of pregnancy to test for specific defects and thus prewarn a mother of a defective baby.

A second scientific exhibit is planned for the 1970 Annual Meeting.

At the January 1969 meeting of the Committee, Daniel Ringelheim, Ph.D., Deputy Assistant Commissioner, Bureau of Special Education and Pupil Personnel, State Department of Education, gave a fine analysis of the Beadleston Act and clarified many points of concern for the school and practicing physician. He also stated that he is recommending changes in the law so that a clearer and more definitive classification and diagnosis can be made. Also all children who come under the Beadleston Act must be evaluated by a child study team,

and a physician must be on this team.

The Committee on Mental Retardation feels that the physician who works primarily with the mentally retarded should be certified as a specialist.

The Chairman wrote the American Board of Pediatrics in this connection, and an answer was received that perhaps a conjoint board with psychiatry could be established. The information was turned over to Robert S. Garber, M.D., President-elect of the American Psychiatric Society and Chairman of MSNJ's Council on Mental Health.

We are in the process of establishing, in conjunction with the Subcommittee on Mental Retardation of the New Jersey Chapter of the Academy of Pediatrics, a series of lectures by physicians who have much knowledge of mental retardation, to be presented to those hospital staffs that desire this information. The chairman also chairs that committee, so he will undoubtedly be giving some of the lectures.

There appears to be a much improved working rapport with the Division of Mental Retardation of the Department of Institutions and Agencies. Dr. Butler has been helpful and regularly attends our Committee meetings.

Members of the Committee have testified before the A.P.A. team investigating the Mental Health set-up in the State of New Jersey.

We have been unable to date to establish a rapport with the parents' groups in the Association for Mental Retardation. However, it is hoped that this objective will be realized before June.

Approved (page 438)

Seizures

J. Lloyd Morrow, M.D., Chairman, Passaic

(Reference Committee "F")

The Special Committee on Seizures met on three occasions with the Executive Director, Executive Assistant, various officers of the Society, and invited guests.

The Committee concerned itself primarily with the existing discriminatory and punitive New Jersey Legislation on convulsive disorders and the fate of its proposed Legislation entitled, "AN ACT, concerning reporting of epilepsy and repealing Sections 26:5-1 through 26:5-13 of the Revised Statutes." However, at this time the Committee has been informed that the Act, introduced by Senator Beadleston, (S-573) unanimously passed in the Senate and is awaiting the deliberations of the Assembly.

The Committee devoted much of its principal efforts and study to a simplified delineation of the treatment of seizure disorders to be recorded in the form of a small card, and readily accessible to the physician in need of such information. Treatment was placed primarily on the level of clinical categories rather than on the basis of the various classifications of seizures which could possibly confuse rather than assist in the practice of medicine. However, a continuing effort is being made to establish satisfactory classifications of seizure disorders acceptable to the Committee.

An attempt was made to contact the committees on seizures of the component medical

societies both for informational and cooperational purposes. The results of this survey resulted in the confirmation of the prior opinion of the Committee that the component societies have dealt with the seizure problems in a reasonable manner and are working with community agencies for the purpose of public information.

In our continuing cooperation with Jarvis Smith, M.D., Director of the New Jersey Rehabilitation Commission and with Miss Marion Updike, A.C.S.W., Director of the New Jersey Consultation Services for Neurological Diseases, Neuro-Psychiatric Institute, it was made clear that our Committee stood ready to be of assistance to all State Agencies in any helpful, consultative collaboration.

At our last meeting on 25 March 1970, the hope was expressed that should the attempted revision of the currently undesirable legislation on convulsive disorders occur, that the Committee will make plans for a meeting to inform the component societies of the responsibilities of the individual physician under the new legislation and the role of the practicing physician in the management of seizure disorders as a clinical and social entity. The title of this meeting will be "The Epilepsy Problem Revisited."

Approved with recommendation (page 438)

Administrative Council

Public Health

Rudolph G. Matflerd, M.D., Chairman, New Brunswick

(Reference Committee "G")

This Council considered a great many matters reported from its special committees and several referrals from the Board of Trustees. In order to avoid a duplication of effort the detailed reports of the special committees will follow this report. We shall address ourselves only to matters not appearing in those reports.

Immunizations of Infants and Children

At its meeting on 19 October 1969 the Board of Trustees referred to the Council for recommended guidelines the question of the indicated time intervals between boosters for tetanus toxoid. Subsequently we contacted the New Jersey State Department of Health, and on 9 March 1970 received an official reply embodying their recommendations. This material is available upon request from the Executive Offices.

The question was raised as to why certain strains of the poliovaccine require a booster. This matter was also referred to the State Department of Health but thus far we have not received an official response.

Hospital Perinatal Study Guide

At the request of the Special Committee on Child Health we reconsidered the aforementioned topic and after extensive discussion disapproved the recommended guide. The data required, it was felt, constitutes a duplication of efforts which renders it impractical because of limitations of both time and manpower, since almost all of the information called for is already a part of the hospital records and is available to requesting physicians at any time.

Salmonellosis

With the increasing use of frozen foods, several deaths attributable to salmonellosis as the result of improper thawing and cooking of frozen meats have occurred. The State Department of Health has been requested by The Medical Society of New Jersey to advise the public, at periodic intervals, of the proper method of thawing and cooking frozen foods.

Toxic Encephalopathy

The Council was informed of a fatality which resulted from the use of a phenothiazine drug. The Council directed that a letter be sent to the New Jersey State Department of Health asking for more information concerning toxic encephalopathy occurring after the use of phenothiazine derivatives in the usual recommended dosage, and suggesting that in this connection the Department issue an advisory to all New Jersey physicians.

I wish to thank the members of the Council and the Special Committees for their diligence and dedication during the past year.

Approved (page 440)

Special Committees to Council on Public Health

Cancer Control

John L. Olpp, M.D., Chairman, Englewood

(Reference Committee "G")

Continuing education and cancer detection screening programs have constituted the major elements of our activity this past year. Attention was focused on the New Jersey Society of Pathologist's program on Pathology and Cancer, which is an excellent vehicle for post-graduate education.

Through the efforts of this Committee and other interested groups, the New Jersey Division of the American Cancer Society purchased four manikins for physician education in proctosigmoidoscopic examinations, additional money has been allocated for the purchase of two more manikins. These manikins are available for hospital and clinic instruction, and the Committee is hopeful that it may present an exhibit on this procedure at the 1971 Annual Meeting.

We considered the various Pap Smear programs in New Jersey, and reached the following conclusion: Beginning at age 15, a Pap smear should be taken on all married females admitted to New Jersey hospitals, and at ages 21 and above if the female hospital patient is unmarried.

Your attention is directed to the cancer abstracts that appear periodically in *The Journal*, and to the "Computer Van" sponsored by the New Jersey Academy of Medicine and the American Cancer Society. The "Van" presents interesting diagnostic situations and suggests therapeutic modalities. It may become a valuable life-saving instrument in the future. It will be at the Atlantic City Hospital from 4 May 1970 to 15 May 1970. Please refer to the November 1969 issue of *The Journal* for a schedule of the "Van's" appearances.

The Committee notes with dismay that the follow-up of most of the tumor registries is very poor (recently four of the participating hospitals in Bergen County have withdrawn) and is therefore contemplating the advisability of a survey of all New Jersey hospitals concerning this matter.

We will also address ourselves in the coming year to the feasibility of a pilot study of a multiphasic screening program similar to that conducted by the Kaiser Permanente Plan, but at present we have no definitive proposal.

Remember — the key to cancer control is awareness and early diagnosis.

Approved with notations (page 440)

Child Health

William J. Farley, M.D., Chairman, Nutley

(Reference Committee "G")

Rubella Immunization

Mass immunization programs to eradicate rubella in New Jersey were discussed and planned with representatives of the New Jersey State Department of Health. Appropriate recommendations were submitted to the Council on Public Health and subsequently to the Board of Trustees. Both of these groups approved of the proposals and they were transmitted by the Board to the Commissioner of Health and the Commissioner of Education in support of Statewide immunization programs.

Drug Abuse

This increasingly complex problem is a patent reality in the juvenile community. It is essential that preventive programs in schools and throughout the communities be commenced with adequate medical guidance. Physician apathy must come to an end. The active involvement of all physicians is urged. Informational material to facilitate participation in community action programs will be prepared by this committee.

The School Physician

The enactment of a Society-sponsored statute which permits the school physician to accept the health appraisal and examination report of a child's personal physician will enable the school physician to assume a new and more worthwhile role in the school health program. He will find the much needed time to become a true medical advisor and a consultant in essential areas of the health education curriculum, i.e., family life counseling, drug abuse, and student activities, as well as to participate effectively in the study of the problem child.

Guidelines on School Health Services

Members and consultants of the committee have assisted the Office of Health, Safety and Physical Education of the State Department of Education in a revision of their Guidelines, particularly the section dealing with the responsibilities of the school physician. The new Guidelines will be distributed to all school districts.

Advisory Council on the Handicapped Child

Your Chairman has regularly attended meetings of this advisory committee to the Office of Special Education of the State Department of Education. Concern has been voiced over the position of the school physician on the Basic Child Study Team in the identification, classification and educational programming of the handicapped child. New rules and regulations pertaining to the Special Education Program are being formulated. Conversely an "Advisory Council of School Health" was strongly suggested to function in a manner similar to the Advisory Council on the Handicapped Child in areas now receiving inadequate attention.

Conference on Comprehensive Child Care

This committee has worked with the New Jersey Public Health Association and the New Jersey Chapter of the American Academy of Pediatrics to co-sponsor with The Medical Society of New Jersey a conference on the essential needs of children. Outstanding speakers will discuss the role of genetic background, perinatal problems, child health supervision, the family, education, and environmental and cultural factors on child development.

The conference will be held on Wednesday, 22 April 1970, at the Holiday Inn in North Brunswick.

Future Projects

a. *Handbook on the Emergency Care of the Severely Injured and Ill Child*—The committee will continue to work on the preparation of a useful guide for the hospital emergency room in cooperation with the Committee on Emergency Medical Care.

b. *Guidelines for Child Health Supervision*—This reference booklet in outline form is felt to be of major importance in the development of adequate standards of comprehensive child care and guidance.

Approved (page 440)

Conservation of Vision, Hearing and Speech

Frank B. Vanderbeek, M.D., Chairman, Paterson

(Reference Committee "G")

At its November (1969) meeting the Committee on the Conservation of Vision, Hearing, and Speech reviewed the results of the 1969 Eye Health Screening Program, conducted in September, under the Chairmanship of Dr. Alfonse A. Cinotti.

There were 83 participating Centers. The total number screened was 11,114. The total number of negative results was 5,939. The total number of positive results was 5,175. The total number of tonometry suspects was 464.

The Committee considered this Program to have been quite successful and recommends that it be repeated in September of 1970.

Dr. Cinotti informed the Committee that the Lions Club has a Sight Committee which has been very useful to the Eye Health Screening Program, especially in the larger cities. Their members have assisted in transporting invalids to the Screening Centers, by doing volunteer work at the Centers, and by advertising at their own expense. In consequence of this, the Committee recommended that the Board of Trustees invite the Lions Club of New Jersey to be a cooperating agency for the Eye Health Screening Program. The Board approved that recommendation.

Some changes in the method of reporting the results by the physicians-in-charge of the Centers were considered and recommended for use hereafter to simplify record keeping.

The matter of the diagnostic use of eye drops by Optometrists was again discussed in detail.

The Board of Trustees, at its April 20, 1969 meeting, set up a special committee consisting of the Chairman and Vice Chairman of the Council on Legislation, two representatives of the Committee on the Conservation of Vision, Hearing and Speech, Legal Counsel, the Ex-

ecutive Director and the Assistant to the Executive Director, and representatives of the New Jersey Academy of Ophthalmology and Otolaryngology. The special committee is to advise the Board of Trustees on the means to be taken to prohibit the use of drugs by optometrists.

The Committee recommended that the Board of Trustees request the New Jersey Academy of Ophthalmology and Otolaryngology to circulate its membership for reports of adverse reactions to topical medications administered by optometrists, and to supply general information concerning the dangers of these medications.

The President of the Academy informed the Committee that the Academy would be at the Society's disposal in this regard.

Further discussion revolved around the fact that optometrists may instill drops into the eyes for diagnostic purposes only, although they may not legally prescribe or obtain drugs from any source. The question was raised: "If optometrists—according to law—cannot prescribe or obtain drugs, how are they obtaining them?" To this end, the Committee recommended:

That a letter of complaint be addressed to the State Board of Medical Examiners that there seems to be an illegal use and procurement of drugs by optometrists. The Medical Society of New Jersey requests that steps be taken to eliminate this situation.

An invitation was extended to the Committee to present an exhibit at The Medical Society of New Jersey's 1970 Annual Meeting in Atlantic City. The Committee agreed to supply an exhibit on Dyslexia. The New Jersey Academy of Ophthalmology and Otolaryngology offered assistance in the project.

Discussion of the expenses incurred in connection with the Committee's exhibit at the 1969 Annual Meeting revealed that some of the individual Committee members absorbed a large portion of the cost. Therefore, the Committee recommended that the total expenses of the exhibit at The Medical Society of New Jersey's 1970 Annual Meeting in Atlantic City by the Committee on the Conservation of Vision, Hearing and Speech, be defrayed by The Medical Society of New Jersey.

Approved (page 440)

Environmental Health

Roslyn Barbash, M.D., Chairman, Teaneck

(Reference Committee "G")

The change of the committee's title from "Air Pollution Control" to "Environmental Health" is a clear indicator of the broadened horizon of its members and a greater insight into the need for the coordination of many disciplines to solve the interwoven problems of our environment. The following was accomplished this year through recommendations of this committee:

1. Recognizing that air pollution disregards geographical boundaries, communication was established with the medical societies of the states which share our "Air Shed" (Pennsylvania, Delaware, Connecticut, New York) urging that the members actively support ambient air standards as stringent as those adopted in New Jersey. The response was encouraging.

2. Aware of the pressing need to preserve our ecological balance and of the rapid disappearance of open land, MSNJ went on record to urge a moratorium on development in the Hackensack Meadow Lands until ecologists were consulted and would provide a long-range view of all the facets of the problems inherent in the use of those open lands ringed by 11 million people. A revised Master Plan should then be prepared, incorporating their suggestions.

3. Cognizant of the major role in pollution played by the internal combustion machine and of the health and safety hazards of over-congested highways, MSNJ communicated its concern to the State Department of Transportation and urged the control of harmful emissions and the development of state-wide, alternative, safe, and pollution-free mass transportation. The cooperation of MSNJ in such a program was offered.

4. Anticipating greater interest in the environment this year by the general membership, arrangements were made with the Division of Clean Air and Water for an exhibition at the Annual Meeting in Atlantic City.

5. Appreciating the present enthusiastic interest in Environment, committee members are participating in programs throughout the State in the grade schools, high schools, colleges, medical schools, and citizens groups. A call to take part in these programs has been sent to each of the County Societies.

Approved (page 440)

Maternal and Infant Welfare

John D. Preece, M.D., Chairman, Trenton

(Reference Committee "G")

Maternal Deaths

The Committee conducted a detailed review of the 1968 maternal deaths in New Jersey as reported by the field physicians.

In the course of this review, it was observed that the reports of field physicians from certain counties are either lacking in detail or completely inadequate. We concluded that the present method of selecting and compensating field physicians is not satisfactory. Therefore, with the concurrence and approval of the Board of Trustees the following recommendations were adopted:

1. That the Special Committee on Maternal and Infant Welfare of The Medical Society of New Jersey nominate an outstanding physician, for appointment by the State Department of Health as Principal Field Physician, to investigate and submit reports to this Committee on maternal deaths throughout the State, and that the compensation for this service be set at an agreed upon per diem plus expenses.

2. That if the volume of deaths to be investigated and reported in the view of the designated field physician proves excessive, he be authorized to designate a deputy to assist him in his work.

It is the intention of the Committee that the dependable members of the present field physicians' group will continue as consultants to the Committee and will be invited to attend and participate in those meetings of the Committee dealing with the reports on maternal deaths.

Oral Contraceptives

The Committee considered the question of the possible causation of death by the production of emboli attributable to the use of oral contraceptives. It was agreed that at the present time there is no dependable basis for statistically valid conclusions, because the deaths of all women of a child bearing age must be checked in order to accurately trace a causal connection with the use of oral contraceptives.

The Committee decided that the State Department of Health and the Bureau of Vital Statistics should be requested to screen out all deaths of females of child bearing age presenting a history of thrombosis or emboli and also to reflect any evidence cited on the death report that the patient was taking oral contraceptive medication. Findings are to be reported to this Committee for investigation, compilation, and statistical evaluation.

The Committee was of the opinion that some guidelines for practitioners are indicated at this time, and submitted the following recommendations to the Board of Trustees, which were subsequently approved by the Board:

1. That The Medical Society of New Jersey urge all member-physicians to perform cytologic smears at least annually on all their women patients where indicated.

Approved (page 440)

2. That all women on the contraceptive pill be seen by their physician every six months, as indeed all female patients should be.

Disapproved (page 440)

3. That no prescription for oral contraceptives be written for longer than a six-month period.

Approved (page 440)

4. That The Medical Society of New Jersey urge the New Jersey Pharmaceutical Association to call upon all its members not to re-fill prescriptions for oral contraceptives for longer than a total period of six months, except on the specific direction of the patient's physician.

Approved (page 440)

Mixing of Obstetrical (and Gynecological Patients

The experience arising out of the mixing of obstetrical and gynecological patients was reviewed. It was the consensus of the Committee that the program is working without complications in the hospitals using it.

Approved with exception of recommendation #2 above (page 440)

Administrative Council

Public Relations

John J. Crosby, Jr., M.D., Chairman, Jersey City

(Reference Committee "F")

The Council on Public Relations consists of twelve members whose function it is to suggest, evaluate, and carry out approved programs and projects calculated to further good public relations for the Society.

Our members are reminded that the Council can play only a formal and limited part in the generation and preservation of good public relations. Every physician must be constantly aware that everything that he says

and does—or fails to say or do—every contact he makes with his patients or his colleagues has a significant impact, for good or ill, on the public relations of Medicine. Some years ago the Council on Public Relations tersely advised our members: "Remember, Doctor, to your patients you are organized medicine." The advice is still timely.

Continuing Projects

At its reorganization meeting, the Council decided to maintain all its regular, continuing projects and procedures, as follows:

1) Publication and distribution of:

(a) *Junior Health Hints* to schools and public libraries

(b) *Membership Newsletter*, including the annual compilation of a bound, indexed set to component societies

(c) *Periodic Newsletter* and bulletins to cooperating agencies/individuals as required

2) Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business and interests, including:

(a) The Eye Health Screening Program

(b) The Annual Meeting

(c) Child Safety Week

(d) Selected official programs and activities

3) Responsibility for bestowal of the Golden Merit Award

4) Responsibility for the informational center and press releases at the annual meeting

5) Encouragement of continuance—or establishment—of orientation programs for new members under sponsorship of component societies

6) Encouragement of statewide emergency medical care coverage, particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the 1965 House of Delegates and printed in the "Appendix of Reference Information" of the *Membership Directory*

7) Encouragement of Future Physicians Clubs in each county, through service as a clearinghouse at state level

Golden Merit Award

The 1969 Golden Merit Award was bestowed upon 42 members of the Society, 21 of whom received the award personally in Atlantic City. This brings the total recipients of the Golden Merit Award since its inception in 1957 to 580. Thus far this year, 28 candidates have been nominated by 13 component societies for the 1970 Golden Merit Award. Following the ceremonies this year, the recipients and their families will be guests of the Society at an informal reception, as they have in preceding years.

New Members

The Council is currently preparing a list of specifics for the information and guidance of new members which is to be distributed to the component societies along with copies of the "Basic Concepts Underlying the Provision of Professional Medical Care" for their use in processing new members through their orientation programs.

Medical Students

The President of MSNJ informed the Council of the Board's intention of inviting medical students from the New Jersey College of Medicine and Dentistry and the Rutgers Medical School to attend MSNJ's Annual Meeting in Atlantic City on one of the days of the scientific programs so that the students may have an opportunity to meet and talk with practicing New Jersey physicians and surgeons.

The Council felt that this was a step in the right direction for better public relations between medical students and physicians of New Jersey.

Approved with notations (page 439)

New Marijuana Pamphlet

Doctors are frequently asked about marijuana. Does it lead to heroin addiction, or the taking of LSD? Or is it less harmful than cocktails and highballs? A new, readable brochure on marijuana is available from the Public Affairs Committee, 381 Park Avenue, South, New York 10016, for 25¢. This compact pamphlet (#436) provides objective data on many aspects of the subject.

Special Committees

Admission of Osteopaths to MSNJ Membership

Elbert H. Pogue, M.D., Chairman, Elizabeth

(Reference Committee "A")

The Special Committee on the Admission of Osteopaths to MSNJ Membership was appointed by the Board of Trustees as the result of the action of the 1969 House of Delegates. The House approved the report of Reference Committee "A" (Addenda, page 381) which recommended that ". . . a special committee be established by the Board of Trustees to study this matter in depth and detail and to submit its report and recommendations to the 1970 House of Delegates."

The committee appointed was as follows: Elbert H. Pogue, M.D., Elizabeth, Chairman; Louis F. Albright, M.D., Spring Lake; A. Guy Campo, M.D., Westville; John J. Crosby, Jr., M.D., Jersey City; and Raymond A. McCormack, Jr., M.D., Trenton. The committee met three times: Sunday, 7 December 1969; Sunday, 8 February 1970; and Wednesday, 18 March 1970. Dr. McCormack was unable to attend the first meeting. Dr. Albright was excused from the second and third meetings because of injury, but kept in touch with the chairman by letter and telephone. Dr. Bertha, Mr. Nevin, and Mr. Maressa attended all three meetings. Dr. Satulsky attended the second and third meetings. All meetings were held at the Society's headquarters in Trenton.

At its first meeting, the committee decided to poll the membership of The Medical Society of New Jersey and to poll the osteopathic physicians of New Jersey to determine the sentiment of these two groups.

The idea of holding hearings in various sections of the state, at which MSNJ members could appear before the committee, was considered but was ruled out as impractical.

For its deliberations, the committee considered the following.

a) AMA actions that have led to our present deliberations and action of the various specialty boards.

b) Result of polls conducted by the committee.

c) Malpractice insurance rates in New Jersey and how such rates will be affected if D.O.s are admitted to MSNJ.

d) Attitude of the osteopathic organizations.

1. *AMA Actions and Action of Specialty Boards*—The fundamental motivation for the drive to fuse osteopathy with medicine was to improve the quality of instruction and training for students seeking their doctoral degrees. Conversion of schools of osteopathy into schools of medicine was the selected and obvious means for this accomplishment.

One school was so converted, in California, and the House of Delegates of the AMA in Atlantic City, in June 1967, directed the Board of Trustees "to begin prompt negotiations directed toward the beginning conversion of schools of osteopathy to schools of medicine." At San Francisco in June 1968 the House expressed disappointment at lack of progress and urged increased efforts to bring about conversion.

In December 1968, in Miami Beach, the Board reported to the AMA House "the possibility of conversion is not promising, at least in the immediate future. It seems apparent that the considerations under which schools of osteopathy would consider the possibility of conversion would be unacceptable to medicine."

Thereupon the AMA Board offered, in Report S, proposals to make possible, by means

other than conversion of the schools, the "assimilation of osteopaths into the mainstream of medicine."

The AMA House softened the language of the proposals contained in Report S, so as to make them suggestions rather than firm recommendations, and adopted the amended version by a vote of 126-97. Thus we have reached the present position, in which state societies by virtue of AMA action have been authorized and encouraged to make changes in their respective bylaws and charters so that osteopathic physicians may be considered for membership in state medical societies and the AMA. Of the States that have moved on this matter, the AMA reports that Illinois, Maryland, and Massachusetts have granted D.O.s active membership, with the following enrollments as of February 1970: Illinois—1; Maryland—5; and Massachusetts—4. Acceptance of graduates of schools of osteopathy as participants in the AMA Intern-Matching Program has also been granted.

The following specialty boards have taken affirmative action to allow certification examinations to D.O.s who have taken AMA approved residencies: Pediatrics, Pathology, Radiology, Preventive Medicine, Physical Medicine and Rehabilitation, and Dermatology.

2. *Polls Conducted by the Special Committee*—The members of MSNJ were polled and a covering letter was sent out with each ballot. The ballot read:

Should The Medical Society of New Jersey take the legislative and other action necessary to open its membership rolls to fully licensed doctors of osteopathy? ——— Yes ——— No

Following are the results:

Ballots	Count	Percentage of Ballots Returned	Percentage of Total Mailing
Mailed	7,875	——	100.0
Returned	4,574	100.0	58.0
Yes	2,609	57.0	33.1
No	1,956	42.8	24.8
Invalid	9	.2	.1
Not Returned	3,301	——	42.0
Total	7,875	100.0	100.0
Yes over No ballots	653	13.0	8.0

The New Jersey Association of Osteopathic Physicians and Surgeons was contacted, informed of our intention of polling its members, and asked for a membership run on envelopes to be supplied by MSNJ. The Association replied through its president by accusing MSNJ of raiding the osteopathic association's membership. It further stated that no decision could be reached on furnishing a list of members until the Association's Executive Board meeting. No further word was received, so MSNJ had to secure a list of osteopathic physicians in New Jersey through its own efforts. The osteopathic physicians were then polled and a covering letter was sent with each ballot. The ballot read:

Would you become a regular, active member of The Medical Society of New Jersey and one of its component societies if such membership were made available to you? ——— Yes ——— No

Following are the results:

Ballots	Count	Percentage of Ballots Returned	Percentage of Total Mailing
Mailed	639	——	100.0
Returned	404	100.0	63.0
Yes	252	62.3	39.5
No	136	33.7	21.2
Invalid	16	4.0	2.5
Not Returned	235	——	36.8
Total	639	100.0	100.0
Yes over No ballots	116	28.7	18.0

3. *Malpractice Insurance*—At the committee's meeting of 18 March 1970, Mr. Britton was present at the invitation of the committee. He discussed the effect that admission of D.O.s would have on the malpractice rates of members of MSNJ who are insured with Employers Insurance of Wausau. (See Communication under "Addenda," page 381)

This report indicates that if this House of Delegates approves action to bring about changes in our Charter and Bylaws so that osteopaths are made eligible for membership in The Medical Society of New Jersey, and the State Legislature acts in accord with this decision, a D.O. joining The Medical Society of New Jersey would be charged a rate three times that of an M.D. member with comparable type of practice, until the following year, when in all likelihood the rate of M.D. mem-

bers of MSNJ would rise approximately 20%. It would be difficult to construe this separate rate of insurance as compatible with the offered "active, regular membership." It should also be kept in mind that this 20% figure of projected across-the-board increase in May 1971 would be in addition to announced rates for 1970 and to the rise in rates that might be anticipated because of "experience, inflation, or other factors." At present the osteopathic rates in New Jersey are roughly six times those of M.D.'s with similar types of practice.

4. *Attitude of the Osteopathic Societies*—It is quite clear the New Jersey Association of Osteopathic Physicians and Surgeons does not approve the action of The Medical Society of New Jersey. A letter addressed to the committee chairman dated 27 February 1970 stated in part ". . . without any advance notice or liaison meeting, Dr. Pogue, your letter of February 16 came as quite a shock. From past pleasant and co-operative relationships, we did not think The Medical Society of New Jersey would even consider raiding our Association's membership. It is amazing that a society with thousands of members, such as yours, would even consider trying to pick off a few of the 530 members of our Association."

In December 1968 the president of the American Osteopathic Association made the following statement, in response to action of the AMA House of Delegates:

"As an independent school of medicine, the osteopathic profession resents the arrogant policies adopted by the AMA in its almost fanatic quest to absorb a competing school of practice. Over the past few years these policies have included actions to take over our colleges, pirate our students and force an unwanted merger on this profession. All of these efforts have failed which accounts for this latest and most desperate action. Apparently the AMA needs us more than we need them.

"The nation's 13,000 osteopathic physicians wish to remain politically separate from the AMA and will reject this latest policy which many people will interpret as an AMA olive branch. We know it is a sprig of poison ivy. We will not be judged, dominated or absorbed by that political body."

Our Legal Counsel has been asked for an opinion as to whether a D.O. who is a member of the New Jersey Association of Osteopathic Physicians and Surgeons and who should elect to join The Medical Society of New Jersey, if such membership is made available to him, would be obligated to give up his membership in the New Jersey Association of Osteopathic Physicians and Surgeons. Legal Counsel is of the opinion that such a D.O. could belong to both organizations and that MSNJ would be unwise to insist that such an applicant must renounce his osteopathic society membership. Thus the possibility of a degree of conflict might exist with such members, especially with regard to the judicial mechanism.

Conclusion

There has been considerable comment by some members of The Medical Society of New Jersey and criticism of this committee because more data were not included in the covering letter that went to each member with the ballot. It was the desire of the committee to be as fair as humanly possible and so the covering letter was worded as carefully and fairly as possible.

Further, the data on malpractice rates came to the committee's attention after the poll was under way.

The members of the special committee have attempted to follow the instructions of the 1969 House of Delegates. We have found ourselves in conflict on many facets of this problem. However, after careful evaluation of all the data at our disposal we have reached a decision that is unanimous.

Recommendation

This committee *recommends* that the House of Delegates *not* take action to permit fully licensed Doctors of Osteopathy to become members of The Medical Society of New Jersey.

Aproved with notations (page 428)

Addenda

From report of Reference Committee "A" (1969)

Resolutions:

a. *Assimilation of Osteopaths*—Resolution #1

b. *Assimilation of Osteopaths*—Resolution #2

These resolutions were exhaustively discussed by some 15 to 20 members in regular meeting as well as by your Committee in executive session. This Committee favors the principle that osteopaths be made eligible for membership in this Society. It is the considered opinion of this Committee, however, that legislative and other action necessary to accomplish this objective should not be initiated until such time as it appears that there is measurable evidence of interest and willingness on the part of a substantial number of osteopaths to join The Medical Society of New Jersey. This matter is obviously of such significance that it should be investigated thoroughly over such period of time as would provide assurance that all aspects of the problem are evaluated.

For the above reasons, your Committee *recommends* that Resolutions #1 and #2 be not adopted at this time, and further *recommends* that a special committee be established by the Board of Trustees to study this matter in depth and detail and to submit its report and recommendations to the 1970 House of Delegates.

Letter from Employers Insurance of Wausau

24 March 1970

Mr. Joseph A. Britton
Joseph A. Britton Agency
15 South Munn Avenue
East Orange, New Jersey 07018

Dear Mr. Britton:

Provided we can get approval of proper rates, we will accept members in good standing of MSNJ whether MD or DO—subject to individual underwriting review. MSNJ can elect to admit DOs to society without prejudice of effect on continuation of program.

Statistics filed by Pacific Indemnity Company must have justified the alarming rate increase. We cannot get loss information relative to New Jersey experience and fear our proposed rates may be inadequate for this increased exposure.

In absence of acceptable loss information, separate rates must be established for osteopaths who are members in good standing of MSNJ until the overall rate structure can be modified to include them. We feel we cannot accept them at our present rates without danger of jeopardy to our program.

We will probably apply the same rules for classes of practice and surcharges. However, until new rates for the entire society are approved, probably effective 1 May 1971, we must charge the osteopaths three times the rates for the M.D.s. This is half of the present rates used by Pacific Indemnity Company.

To have uniformity in the program, we will be willing to rate the DO by class and specialty the same as the MD. In all likelihood, this would result in an increase of approximately 20% for all rates for all members of MSNJ effective about 1 May 1971. In addition to this increase, there could be a further percentage increase based on experience, inflation or other factors.

Very truly yours,
J. FARAGASSO
Underwriter

PATRONIZE

OUR

ADVERTISERS

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "D")

Throughout the year of 1969-1970 emphasis has been placed by the committee on emergency medical care in hospitals. Investigations by governmental authorities have shown that many hospital emergency departments are inadequate, outmoded, and incapable of caring for present patient loads and that local community emergency health service care must improve. This is especially important since the volume of patient flow in emergency departments in hospitals is increasing at least ten per cent each year.

With the approval of the Board of Trustees and the cooperation of the New Jersey Department of Health and the Division of Emergency Health Services, U.S. Public Health Service, a Training Program for Emergency Room Physicians was successfully completed. This was the first formal program held in the United States; it had active cooperation from ten New Jersey hospitals and various New Jersey specialists in the field of medicine, surgery, orthopedics, pediatrics, psychiatry, neurosurgery, and anesthesiology. The Committee on Emergency Medical Care has recommended that this program be held in all general hospitals annually as an on-going program.

Each component society in the state should establish a "Committee on Emergency Medical Care" and include in its purview the areas presently dealt with by such committees as the Committees on Civil Defense, Disaster Medical Care, or similar committees. Effectuation of this recommendation should insure uniformity and efficiency of planning and delivering emergency medical care under all emergent circumstances, natural or man-made.

At the inception of the program several years ago, the Board of Trustees recorded itself as being in favor of the Medical Self-Help Training Courses in High Schools. Although, this program has been highly successful, the Committee on Emergency Medical Care has recommended and the Board has approved that this course be continued in all high schools and that the Department of Education of New Jersey be requested to include it as a mandatory curricular item for all New Jersey high schools.

Recommendations

1. That the Medical Society of New Jersey urge the New Jersey Department of Transportation to place adequate and sufficient road signs on major highways and thoroughfares indicating the locations and names of nearby hospitals, and that the personnel in the toll booths along the various toll highways be prepared to instruct inquiring motorists as to the location of nearby hospitals.

2. That the Medical Society of New Jersey endorse the principle of mobile Coronary Care Units and urge the component societies to contact the various hospitals within their locale concerning the practicability of such programs.

(Recommendations 1 and 2 were previously approved by the Board of Trustees.)

Since the New Jersey State Emergency Medical Service Plan is in the final stages of development under the standards of the National Highway Safety Act of 1966, and since it is the obligation of the Committee on Emergency Medical Care to see to the rendering of quality emergent medical care in New Jersey, it was decided that a training program for ambulance personnel is essential. Therefore, a pilot program will be developed by the Committee and will be given in the state. When this program is finalized, it will be the standard program recommended. In development of this pilot program, the "Guidelines for Training of Ambulance Personnel," as established by the National Academy of Sciences—National Research Council, will be utilized.

Approved with notations (page 432)

Medicine and Religion

Luke A. Mulligan, M.D., Chairman, Fort Lee

(Reference Committee "D")

The efforts of the committee this year were directed to achieving the establishment and maintenance in each component society of a committee on medicine and religion, and to cooperating with the Department of Medicine and Religion of the American Medical Association in the endeavor to achieve fuller understanding and collaboration between members of the clergy and members of the medical profession, for the purpose of more effectively serving the total interests of patients. No formal meeting of the committee was held.

We are able to report at this time that committees on medicine and religion have been established in thirteen of our twenty-one component societies. It is our hope that in the near future committees will be in operation in all of our county societies.

Your chairman participated in an AMA sponsored regional meeting held at La-Guardia Airport in early spring. In attendance were representatives of state medical societies from West Virginia to Maine. The meeting adopted as its goal the establishment of contact with theological seminaries for the purpose of inducing their faculties to include as a regular curricular component a course in the interrelationships of medicine and religion.

It was agreed that component medical societies should be asked to further this project in their localities, with the suggestion that small societies might associate to work jointly toward this end. It was further agreed that county societies on medicine and religion should be stimulated to bring about efficient and intimate cooperative relationships between physician members of hospital staffs and the chaplains assigned to their hospitals.

Approved (page 432)

Project Hope/Vietnam

Thomas C. DeCecio, M.D., Chairman, Cliffside Park

(Reference Committee "B")

At the 1968 Annual Meeting, the House of Delegates voted to approve the recommendation of the Board of Trustees, "That Project Hope and Vietnam be established as a joint continuing program of The Medical Society of New Jersey, subject to any subsequent modification by the House of Delegates; and that a maximum of six fellowships be awarded annually on a 'first-come, first-served' basis, each carrying a stipend of $1,000 for a 60-day tour of duty aboard the S. S. HOPE, her sistership, or voluntary service in Vietnam."

During the course of the year 1969-70 the following two applications were received and authorized:

PROJECT HOPE FELLOWSHIPS

Frank Colantuono, M.D. (Bergen County) . . . $1,000.00

*John J. Flanagan, M.D. (Monmouth County) . . . $1,000.00

*Dr. Flanagan served for two months on the S. S. HOPE in Tunisia. In consequence of that service, Dr. Flanagan qualified for a grant of $1,000 under the program. However, Dr. Flanagan applied for the grant with the stipulation that the money be donated to Project Hope (The People-to-People Health Foundation in Washington, D. C.) by The Medical Society of New Jersey in his name. Meeting on 18 January 1970, the Board of Trustees acted favorably upon Dr. Flanagan's application and granted his request.

Approved (page 430)

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

The committee reviewed several brochures from various financial companies offering sundry types of investment programs suitable for Keogh plans. These have had nothing new to offer and were not further explored.

In accordance with the directive of the 1969 House of Delegates, this committee investigated and explored means whereby the variable annuity fixed dollar program of the Prudential Insurance Company as presently in effect in the Essex County Medical Society and the Union County Medical Society could be made available to members of other component societies throughout the State. Investigation showed that this program could not be made available to members on an individual basis.

Accordingly, with details worked out by the members of the Committee on the Retirement Plan and the Prudential Company, trust agreements are being drawn up which will be presented to the House of Delegates through the Board of Trustees. These will be known as the Medical Society of New Jersey Plan A (the Keogh Version) and The Medical Society of New Jersey Plan B (the Corporate Version).

On March 15, 1970, the Board of Trustees appointed the members of this Committee—Nicholas E. Marchione, M.D., Albert F. Moriconi, M.D., and Richard R. Chamberlain, M.D.—to be Trustees of The Medical Society of New Jersey Retirement Plan Trusts, to take such steps as are necessary and proper to the formal establishment of this retirement program so that it will be available to the members. The administrator of the program is to be the E. & W. Blanksteen Agency, Inc.

These formal trust agreements when completed, are to be reviewed by the Society's Legal Counsel. He will then advise the Board as to their propriety and acceptability. When all these procedures have been accomplished, the programs will be made available to the membership at large.

Approved (page 431)

Supplemental Report

Not included in the regular annual report of the Committee on Retirement Plan for Physicians was a progress report of the Pro Services, Inc., administrators of the Pro Plan —Master Keogh Plan as devised for physicians in New Jersey.

The Pro Plan announces that it now has a total participation of fifteen counties: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Gloucester, Hudson, Hunterdon, Morris, Passaic, Salem, Sussex, Union and Warren County.

In addition to their Master Keogh Plan, there is now available a Pro Professional Corporation Plan, which has been approved by the Internal Revenue. The corporate plan now becomes part of their Keogh plan, giving eligible participants the opportunity to meet their financial needs either as self-employed physicians or as employees of a professional corporation.

The Pro Plan as presently constructed could very well be modified and merged into a State Plan. Members of our committee are familiar with this plan and its flexibility, and it is my personal belief, as well as the opinion of other members of my committee, that this plan warrants our approval on a state-wide basis, and that the Pro Plan could offer a prototype master plan designed for the State, to be submitted to our Legal Counsel for review

and advice, similar to the procedure outlined for the Prudential Insurance Company.

As previously stated in a report submitted to the Board of Trustees on 16 December 1969, we feel it would be fair and equitable to assure that other companies may also be given State recognition and approval if their plans are in conformity with the standards acceptable to our Society through its Retirement Plan Committee and its Legal Counsel.

Approved (page 431)

Traffic Safety

Irwin S. Smith, M.D., Chairman, Willingboro

(Reference Committee "D")

The committee is pleased to report that with the change in the State administration a fine working rapport with the Division of Motor Vehicles has been established. The Chief of Traffic Safety Service has agreed to become a regular consultant to the committee. Related in detail below are the activities of the committee during the past year.

School Bus Safety

The 1969 House of Delegates adopted Resolution #19 relating to school bus safety and directed that appropriate steps be taken to implement the principles of that resolution. The committee forwarded those items which seemed worthwhile to the New Jersey State Department of Education for evaluation, comment, and possible implementation and is in the process of meeting with a representative of the Department to discuss this matter.

Determination of Safety or Competence of Automobile Drivers

The aforementioned topic was discussed with the Chief of Traffic Safety Service with particular emphasis on the physician's certification statement that appears on the various forms used by the Division of Motor Vehicles. The committee reiterated the Society's position that licensing is a function of the Division and the physician should not be obliged to certify the safety or competence of automobile drivers. Assurances were received that a similar position is taken by the Division and that the objection to the current phraseology will be taken under advisement in the drafting of future forms.

Examination and Re-examination of Automobile Drivers

The implementation of a program requiring physical examinations prior to the issuance of a driver's license and periodic re-examination thereafter is presently under consideration by the Division of Motor Vehicles. A study is being conducted, and further developments will be brought to the attention of the committee. The launching of such a program in the near future is highly doubtful.

Driving While Under the Influence of Alcohol

The committee discussed the problem of the intoxicated driver. At the present time there is proposed legislation regarding driving while under the influence of alcohol. Copies of the bill will be distributed to the committee for its perusal.

Driving While Under the Influence of Drugs

The illicit use of drugs is creating not only a medical-sociological crisis, but also a highway safety issue. Current New Jersey law provides that a person found to be using unprescribed drugs will automatically have his driving privileges suspended for one year. Whether or not this legislation will have a significant effect on highway safety or be a factor in controlling the illicit drug flow is a matter for future study.

Epileptic Seizure Reporting

A bill drafted by the Special Committee on Seizures and processed through the Council on Legislation has been introduced by Senator Beadleston and has the active support of this committee. This bill (S-573) would hopefully replace existing law which is discriminatory against epileptics and imposes an unnecessary obligation on attending physicians with meaningful legislation that would safeguard the public against the hazard posed by drivers of motor vehicles who are subject to uncontrollable convulsive seizures whether due to epilepsy or other causes.

Chemical Testing for Alcoholic Intoxication

Periodically the Executive Offices receive inquiries from member-physicians as to the legal ramifications in performing a chemical test for intoxication upon a patient at the request of the police. This matter has been referred to the Division of Motor Vehicles for comment and reply.

As you can see the issues before this committee are controversial, diverse, and complicated. Hopefully, with the establishment of meaningful dialogue with and the cooperation of the Division of Motor Vehicles we will in the future be able to formulate programs and concepts that will help make New Jersey's highways safer for everyone.

Approved (page 432)

New AMA Directory

With the addition of 23,000 new names, the *American Medical Directory* has become the largest and most complete medical register in the world.

Added to the list of all physicians in the U.S., its possessions, and those serving in foreign countries, the *Directory* now includes a new listing of AMA affiliate (non-M.D.) members. This category includes such allied health personnel as dentists, scientists, and others who have earned distinction in their fields. The addition of this group brings the total list of names to over 326,000.

The information in the three volumes (one alphabetically indexed, and two geographically indexed) is current as of August 31, 1969. Each listing includes complete name and address, denotes AMA membership, birth date, medical education, year of licensure, year of certification, specialty board certification, primary and secondary specialties, type of practice, specialty societies, and professional appointments.

The three volumes which comprise this 25th edition are $90 per set (single volumes not available) within North America, and $100 for all other countries. Checks must accompany orders to American Medical Association, 535 North Dearborn Street, Chicago 60610. (Orders on medical society letterhead receive 50 per cent discount.)

Medical-Surgical Plan of New Jersey

Joseph P. Donnelly, M.D., President, Newark

(Reference Committee "C")

I am pleased to report that 1969 was, by and large, a good year for Medical-Surgical Plan. Some of the highlights on the plus side include:

(a) The greatest annual membership gain in 17 years—234,750 persons added to the rolls, bringing the enrollment to 3,331,522. The Plan's growth moved it up from fifth to fourth largest of all Blue Shield Plans.

(b) Claims incurred for benefits on behalf of members set a new record, totaling $72.5 million, an increase of $14 million over the preceding year.

(c) The number of services paid for also reached a new high of 1,604,036 up 320,710 from 1968.

(d) The number of Participating Physicians under the Basic Program increased to a record high of 7,642, a gain of 475 during the year.

(e) Extended Benefits Rider 65, introduced early in the year to supplement the "Blue Cross and Blue Shield 65" program with benefits for a number of services in the doctor's office, received excellent acceptance and is now held by over 91,000 persons, or nearly 70% of the "65" subscribers.

(f) Rider J continued to show strong gains, and now covers over 1.6 million members.

(g) A Dental Program was developed, together with Blue Cross and the Dental Service Corporation, which will be marketed this year.

There were, of course, some problems during the year. Although a new computer claim system which was put into operation in June functioned well, there was a slowdown in payments due chiefly to the difficulty in recruiting sufficient qualified personnel, plus an upsurge in the volume of claims received, which escalated to over 8,000 per day. Significant expansion of personnel, together with administrative realignments toward the end of the year, made considerable inroads on the problem, which hopefully is now generally rectified. As of this writing, the backlog of claims on hand in our own shop has been reduced by 57% since the end of 1969. The overall backlog, including claims awaiting the processing functions performed by Hospital Service Plan, has been reduced by 26% during the same period. So we are beginning to see daylight.

Although it was necessary to deplete the Plan's reserves by nearly half a million dollars, at year's end the reserves amounted to $8.5 million, equivalent to a little over a month of claims and operating expense.

While the enrollment of Participating Physicians under the Basic Program showed a gratifying increase, participation under the Prevailing Fee Program continued to lag. I cannot stress too strongly the importance to the Profession of participating in this program. Perhaps participation has lagged because virtually all of the enrollment under Prevailing Fee coverage has been in the national account area—Steel, Motors, Federal Employees and CHAMPUS programs—and the great majority of Prevailing Fee cases so far have been limited to areas where there is a high concentration of persons covered by one of the foregoing programs. *This will not be the case in the near future.* We have developed a Prevailing Fee Program for intrastate—as well as national—accounts. We expect this local program to "take off" very shortly—in fact, we think it will replace our Basic Program in many local accounts—and the benefits of the program to the subscriber and the physician are considerable.

To put it briefly: The subscriber has his bills for eligible services by a Participating Physician paid in full, regardless of his income; the Participating Physician receives his usual, customary and reasonable charges paid directly to him. We regard this as a great step forward in the Blue Shield tradition of service benefits—providing under Prevailing Fee full payment for eligible services by a Participating Physician.

There also may have been an area of misunderstanding over participating in this program, which I will take this opportunity to clarify. A Participating Physician under the Basic Blue Shield program *is not* automatically a Participating Physician under Prevailing Fee. Conversely, a doctor may participate under Prevailing Fee *without* being a Participating Physician under the Basic program. Participating Physicians under either program are paid directly *under that particular program*; however, only physicians who participate in *both* programs receive direct payment under *both* programs. There is nothing to lose, and a great deal to be gained, by participating under Prevailing Fee. I earnestly commend it to the consideration of those physicians who have not yet elected to participate under this program. It is one of the strongest weapons the profession has to keep the private practice of medicine private, by receiving usual and customary reimbursement under a Blue Shield prepayment program.

The continued growth of Rider J coverage has been matched by increased utilization of Rider benefits, and I would like to offer a word in this regard. Rider J was not intended to cover laboratory and other tests connected with health examinations. The annual premium charged for the entire Rider—of which the pathology component represents a very small part—is a little over $10 for an individual. The subscriber's pathology benefit of $25 per year can be wiped out by a battery of diagnostic tests, and at the same time utilization can escalate to the point where the Rider J premium would price itself out of the market. Careful utilization of Rider J by the profession will accomplish two things: (1) It will keep Rider J saleable, and (2) it will conserve the subscriber's benefits and minimize his out-of-pocket payments.

The subject of utilization control in general is receiving increasing attention from the Plan. Elsewhere in this report there is a detailed description of our Utilization Program, to which I will add a word of emphasis. There has been some misapprehension among the profession over our audits of office services, in which a questionnaire is sent to the subscriber. I want to emphasize that these audits are made on a random basis, and there is no stigma attached to any physician whose patient receives a questionnaire. Such audits are a necessary business procedure, as well as being required by NABSP, inasmuch as the Plan is paying out nearly $70 million annually on the basis of physicians' certifications in their Service Reports. Audits of this nature are important when we are called upon by the Department of Banking & Insurance to justify our payments.

It is a source of gratification to me—and more importantly, a mark of recognition to the New Jersey Blue Shield—that in 1969 I was elected a director-at-large of NABSP and appointed chairman of its Professional Relations Committee. Serving on the national level, I have been impressed by the fact that the best Blue Shield Plans derive their strength from the closeness of their rapport with their Medical Societies, and in this respect I feel that the New Jersey Plan is second to none.

A prominent attorney and an outstanding labor leader were added to our Board of Trustees in 1969. They are Mr. Stanley C. Van Ness, the New Jersey State Public Defender, and Mr. Morgan Sweeney, president of the Utility Co-Workers Association. Both have participated actively in Board affairs, and the Board has benefited much from their experience and counsel.

I wish particularly to express the Plan's thanks to the representatives of the various specialty organizations and general practitioners who

have given our Fee Committee and Staff invaluable assistance and advice during the past year. I also wish to convey our appreciation to all the practicing physicians in New Jersey who, with a few exceptions, have attempted to assist in controlling the cost of medical care by maintaining fees that are really usual and customary. Headlines appear in the public press about excessive fees and over-utilization in a few scattered instances, but nothing is ever said about the vast majority of physicians who day in and day out do a great job.

Comparative Balance Sheet December 31, 1969

Assets

	1969	1968
Cash on Hand and in Banks (Working Funds)	$ 1,536,921	$ 1,062,444
Investments	28,285,429	22,799,427
Accounts Receivable—Subscriptions	1,750,072	1,514,115
Accounts Receivable—National Account Program	2,807,632	1,649,590
Accounts Receivable—Federal Employee Program	2,517,905	875,465
Accounts Receivable—Hospital Service Plan	—	486,184
Accounts Receivable—Other	179,662	71,147
Accrued Interest and Dividends Receivable	420,337	306,703
TOTAL ASSETS	$37,497,958	$28,765,075

Liabilities

	1969		1968	
Claims Outstanding:				
Reported	$ 8,365,000		$3,689,000	
Unreported	11,150,000		7,858,000	
National Accounts	1,297,000	$20.812,000	891,000	$12,438,000
Unearned Subscriptions		3,569,979		3,379,692
Accounts Payable—Hospital Service Plan		102,334		—
Accounts Payable—Miscellaneous		1,314,178		1,063,720
Reserve For Group Contract Settlements		2,473,910		2,139,538
Deposits From Other Organizations		643,145		747,309
TOTAL LIABILITIES		$28,915,546		$19,768,259

Reserves

	1969	1968
Securities Valuation	$ 802,850	$ 692,000
Special Contingent	100,000	100,000
Unassigned	7,679,562	8,204,816
TOTAL RESERVES	$ 8,582,412	$ 8,996,816
TOTAL LIABILITIES AND RESERVES	$37,497,958	$28,765,075

Annual Statistics—1969

Table I

Distribution of All Services and Payments

Paid 1969	Total Services	% All Services	Payment	Percent	Payment Per Service
Surgical	603,532	37.6	$29,737,603	48.0	$49.27
Medical	750,004	46.8	19,029,706	30.7	25.37
Obstetrical	43,833	2.7	7,521,629	12.1	171.60
Consultations	58,180	3.6	1,192,366	1.9	20.49
Anesthesia	148,487	9.3	4,552,639	7.3	30.66
Total	1,604,036	100.0	$62,033,943	100.0	$38.67

Table II

Distribution of Rider Services and Payments

	Total Services	% All Services	Payment Amount	Percent	Payment Per Service
Surgical	67,298	15.0	$1,279,780	17.1	$19.02
Medical	6,371	1.4	341,966	4.6	53.68
Diagnostic X-Ray	174,918	39.0	3,397,962	45.4	19.43
X-Ray Therapy	1,006	0.2	168,373	2.3	167.37
Physical Therapy	12,666	2.8	305,056	4.1	24.08
Pathology	186,381	41.6	1,985,485	26.5	10.65
Total	448,640	100.0	$7,478,622	100.0	$16.67

Excludes Federal Claim Data

Table III

Distribution of Earned Subscription Income

Earned Subscription Income .	$81,013,743	100.0%
Incurred Claims	72,579,531	89.6%
Operating Expense	8,125,986	10.0%
Underwriting (Gain)	308,226	.4%

Federal Employee Program

Following is a statement of income and expenses, along with utilization statistics of the 1969 experience of the Federal Employee Program.

Income	$5,093,781	100.0 %
Claims Incurred	4,673,925	91.76
	$ 419,856	8.24
Operating Expense (Estimate)	227,300	4.46
Gain	$ 192,556	3.78%

Paid Basis

Average Exposure (Persons)	122,401
Services per 1,000 Persons Enrolled	505
Average Cost Per Service	$62.57
Number of Services	61,849
Amount Paid	$3,870,078

Claims Incurred

Year	Amount
1969	$72,580,000
1968	58,536,000
1967	53,016,000
1963	40,991,000
1960	31,516,000
1957	22,886,000
1954	13,992,000
1951	6,527,000
1948	1,204,000
1945	208,000
1942	5,000

Incidence Rate

Cases Per 1,000 Persons Enrolled

Year	Incidence
1969	328
1968	304
1967	275
1963	193
1960	166
1957	143
1954	126
1951	112
1948	96
1945	86
1942	40

Civilian Health and Medical Program of the Uniformed Services

Effective December 1. 1967, the Plan, with the approval of The Medical Society of New Jersey, was designated as contractor for the program, which on the same date adopted a usual and customary charges basis of payment, replacing the fixed fee schedule previously utilized.

Following is the claim experience for 1969.

CLAIMS

Period	Received	Declined	Returned Incomplete
Total Claims 1969..	24,511	1,481	8,242

Paid Claims	Amount	On Hand
13,989	$1,273,269	1,123

City of Newark Medical Plan

Effective June 1, 1965, Medical-Surgical Plan of New Jersey assumed the administrative functions of the City of Newark Medical Plan on behalf of Medical Service Administration of New Jersey.

Approved services rendered from January 1, to December 31, 1969, as compared with former years, were:

RELIEF

Year	Number of Cases	Value of Services
1965	1128	$6,287.50
1966	682	3,770.00
1967	831	4,670.00
1968	868	4,857.50
1969	126	632.50

MEDICALLY INDIGENT

Year	Number of Cases	Value of Services
1965	962	$5,585.00
1966	931	5,395.00
1967	482	2,707.50
1968	361	2,137.50
1969	12	70.00

Public Relations Program

Throughout 1969, considerable public relations effort was directed toward solving subscribers' problems that had been brought to the attention of various newspaper "problem-solving" columns, and referred by them to the Plan. This involved ongoing contact with about a dozen newspapers in New Jersey, as well as some out-of-state publications as far away as Ohio and Florida, by correspondence, telephone and personal contact. Since a par-

ticularly sensitive area is created by publication in the press of problems that can reflect adversely upon the Plan, every effort is made to resolve such cases speedily and satisfactorily. A by-product on the plus side of these endeavors is that the Plan's press relations have been generally enhanced by the results.

In all areas of press relations, prompt cooperation was given to special feature writers and reporters seeking information of Plan programs, policies, and procedures, so that published accounts would present the Plan accurately and in proper perspective. Not infrequently the proper orientation of the writer averts publication of erroneous information that could reflect adversely on the Plan; avoidance of unfavorable publicity sometimes can be more important than obtaining favorable publicity. In a few instances where information about the Plan, published without prior consultation with the Public Relations Office, proved erroneous, steps were taken to tactfully set the record straight.

The role of public relations in the Plan's advertising took on added importance during the year, which saw a change in advertising agencies with a shift to increased emphasis on the Blue Shield and Blue Cross "image," and increased prominence being given Blue Shield's role in the total health care picture.

A major public relations program—emanating from National Association of Blue Shield Plans and implemented locally—was the involvement of Blue Shield in the problem of drug abuse. "Drug Abuse: The Chemical Cop-Out," a booklet prepared at a national level, was supplied to Medical-Surgical Plan for distribution to organizations and groups concerned with drug abuse. The reception accorded the booklet far exceeded expectations, nationally and locally, and National Association of Blue Shield Plans experienced considerable difficulty in filling local reorders. Requests received so far by Medical-Surgical Plan are approaching the 40,000 mark; National Association of Blue Shield Plans printings of the booklet have passed the 2 million mark. The National organization also had produced three films on the drug abuse problem. The Public Relations Office procured a set of the films, and as of this writing a number of requests for their loan to organizations concerned with drug abuse are being booked. The films, as well as the drug abuse booklets, carry the imprimatur of Blue Shield, and reflect favorably on the Plan as performing a public service in the interest of better community health.

In 1969 the Plan's Annual Statement and Report to The Medical Society of New Jersey was redesigned in a more attractive and readable format. In this endeavor, as well as many others involving the design and production of informational and educational material, the Public Relations Office wishes to record its appreciation of the assistance provided by the Editorial Services Department of Hospital Service Plan Public Relations, which serves both Blue Cross and Blue Shield.

As in former years, the Public Relations Office, with responsibility for the editorial content of all Medical-Surgical Plan printed material, gave assistance to many individuals and departments of the Plan. These included the President, Executive Vice President, Vice President-Medical Affairs, Administrator, and the Operations, Service and Special Programs and Training Departments, and Physician Relations and Utilization Sections.

The Public Relations Office during the year received helpful counsel and guidance from the Public Relations Committee of the Board of Trustees under the chairmanship of Mr. Lloyd Felmly, retired editor of The Newark News, which resulted, among other things, in adoption of a more meaningful and readable type of monthly report to the Board of Trustees, and in bringing a more detailed understanding of the Plan's advertising program to the Board.

Physician Relations Program

1969 was the most productive year in the history of the Physician Relations Section in number of meetings held, field contacts made and Participating Physicians enrolled.

Gains in broadening the "two-way street" of communication and cooperation between the Plan and its Participating Doctors are reflected in the following figures:

Type of Meeting	Number
Hospital-Medical Staff Meetings	24
Hospital-Physicians' Lounge-Information Desk	180
Doctors' Offices—Personal Visits	1,034
Conventions—Annual Meetings	7
Medical Assistants Meetings	23
Miscellaneous Meetings (Specialty Groups, Emergency Room Groups, Etc.)	89
Total Number of Meetings	1,357

The total number of personal contacts during the year with doctors, their medical assistants and nurses was 10,374, accomplished with a staff of seven persons. We believe that each personal contact made during 1969 helped the medical profession to better understand Blue Shield philosophy, policies, and procedures.

The response from doctors to our Field Program has been gratifying. We encountered no difficulty in scheduling multiple visits in many hospitals throughout the state. The genuine interest and cooperation shown by individual physicians during the course of each meeting is further evidence of the relative success of the program.

At year's end the number of Participating Doctors under the Basic Program stood at a new high of 7,642, a gain over 1968 of 475. Represented in the total are 6,289 Doctors of Medicine, 610 Doctors of Osteopathy, 342 Doctors of Podiatry, 105 Registered Bio-Analytical Laboratories and 296 Doctors of Dental Surgery. These participants, by accepting the Plan's allowances as payment in full for service benefit subscribers, make a vital contribution to the citizens of New Jersey.

This is understood and appreciated by the Physician Relations Section, which records its thanks for the cooperation, loyalty, and dedication of all of our Participating Doctors.

Utilization Program

Subscriber Questionnaires in Office Cases. Questionnaires in office cases are mailed to subscribers on a strictly random sampling basis. The claims are selected with no regard as to name of physician; the only criteria being that the reported services were rendered in the doctor's office. The questionnaire emphasizes that this is a random sampling and that the Plan is interested in the patient's or subscriber's personal recollection of what services were rendered. If a discrepancy is found, a further sampling is made. If a pattern of abuse is evident, the doctor is brought into the picture at this point and the investigation is continued if warranted.

Hospital Audits. A post-audit of physicians' claims is made at least once a year in each hospital in the State. The audit consists of making a comparison between the services as described on the hospital chart and the services as described on the physician's Service Report. Again the claims are selected at random, the only criteria being that the cases to be audited represent a good cross-section sampling including all types of cases—maternity, surgery, anesthesia, medical, and consultation. The hospital Administrator and/or Chief of Staff is notified at least two weeks in advance of the audit. Before conducting the audit, the Plan representative reviews the Plan's Utilization Program with the Administrator and/or Chief of Staff. If irregularities are found, the physician involved is notified directly. If the investigation is to be continued on a larger scale, the doctor is so advised.

Notification to Subscriber. It has been the practice of Blue Shield for some time to notify the subscriber in each instance of payment made to his physician. The notice includes date and amount of payment, name of physician, type of services rendered and a statement as to the terms of the Participating Physician Agreement. Inquiries prompted by the notice of payment, if warranted, are investigated.

Statistical Reports. Quarterly statistical reports are reviewed. Basically, there are two reports. The so-called Physician Profile Report provides a detailed list of all payments to each physician by type of service and diop

code (Diagnosis-Operation) within accommodation. The second quarterly report is by diop code within type of service by physician in descending order by amount. The physician receiving the largest payment for a particular procedure during a particular quarter is listed first, the second highest next, etc. This report will point up a physician whose payments for a particular procedure seem to be out of line with other physicians in the same specialty practicing in the same area. If a situation cannot be satisfactorily resolved between the Plan and the physician, all details are presented to the Plan's Physician Review Committee for a recommendation. The Physician Review Committee is comprised of lay and physician members of the Plan's Board of Trustees and the Plan's attorney.

Computer Rejections. Cross-checking is done by computer between Blue Cros and Blue Shield records. For example, if a physician bills Blue Shield for more days than the hospital has reported to Blue Cross, the claim is automatically rejected and the payment and days are reduced accordingly. The physician is notified as to the reason for the reduction in days. Plan records are noted and if repeated errors occur, further examination of the physician's profile is made.

Referrals from Claims Examiners. Claims examiners, correspondents, and telephone clerks are alerted to refer possible areas of abuse or over-utilization to the Utilization Section for analysis and review.

Flip Chart Presentation. A flip chart presentation is given at hospital staff metings to acquaint physicians with the Utilization Program and as such to act as a deterrent.

Follow-Up Interview. Subscriber interviews are conducted to follow-up on physicians who had previously refunded monies to the Plan because of discrepancies in office cases.

Special Studies. Special studies are conducted involving similar codes with different payments to establish whether a physician consistently bills for the higher paying procedure but actually performs the lower paying procedure.

Utilization Review by Group. Groups with relatively poor claim experience will be reviewed in an effort to pin-point the reason or reasons for high incidence of claims. Statistical reports are obtained for such groups listing claim payment by physician within procedure code.

Enrollment Report

The total membership of Medical-Surgical Plan increased in 1969 by 7.6%, representing a net gain of 234,750 persons based on the addition of 102,013 contracts, the largest membership gain since 1952. Total membership at year-end totaled 3,331,522 members, 45.7% of the State's population. During 1969, as a result of the growth experienced, the Plan moved from fifth to the fourth largest Blue Shield Plan in the nation. Gains in all major lines of business i.e., Group, Left-Group, Non-Group and Complementary coverage were produced in 1969.

Enrollment under the varied Group programs totals 2,719,038 persons, an increase of 195,651 members over the year-end 1968 total. Within the major categories of coverage in the broad Group classification, the following increases are reported. Members covered under the Basic Certificate, both with and without Rider coverage, total 1,736,717, an increase of 52,823 members. Nearly all of this increase is the result of growth reported in the Basic and Rider J category of enrollment. Coverage under the Basic and Basic and Rider classifications currently totals 63.8% of the Group member force. The governmental coverages now account for 12.9% of total Group, reflecting a 52,000 member increase. National Accounts experienced an increase of 28,964 members during 1969, exposure under these programs now totaling 447,848 members. Subscribers and dependents covered under the Plan's Domestic Master contracts totaled 77,399 at year-end, an increase of over 54,000 members during this 12 month period. Complementary coverage added a net total of 6,758

members. In total, 76,209 net contracts were added to the total group classification during 1969, the preponderance of this increase being evidenced in those enrollment categories where broader benefits are available.

Direct Payment membership areas also displayed increases during 1969, the combined total equaling 39,099 members, a 6.7% increase in membership over 1968. Membership transferred from former group coverage was up 10,562 persons. Within the Non-Group categories, a total increase of 18,400 members was recorded, with 15,400 members being added to the basic Non-Group category and 2,956 new Student contracts added. Here, as in Group, the trend toward the selection of broader coverage, through the purchase of Rider J is much in evidence. The net contract growth reported all is in the Basic and Rider classifications of enrollment. The introduction of the Extended Benefits Rider to the "65" program during 1969 assisted in adding to the volume of members enrolled during the year. Of the 136,400 members enrolled under the "65" program, 91,291 or 66.9% also chose to take the Rider in addition to their basic coverage.

Although the projected level of economic growth in the nation and the state in 1970 may impede the production of new enrollments equal to the 1969 totals, continued expansion in those areas where broader levels of benefits are offered is anticipated.

ENROLLMENT GROWTH

Year	Enrollment
1969	3,331,522
1968	3,096,772
1967	2,908,799
1963	2,450,755
1960	2,080,582
1957	1,711,834
1954	1,196,804
1951	669,906
1945	236,604
1942	4,131

Comparative Summary of Operations

		1969			1968	
Subscriptions Earned*		$81,013,743	100.0%		$69,591,590	100.0%
Less:						
Claims Incurred**	$72,579,531		89.6	$58,536,205		84.1
Operating Expenses***	8,125,986		10.0	7,148,371		10.3
		80,705,517	99.6%		65,684,576	94.4%
Gain from Underwriting Operations		$ 308,226	.4%		$ 3,907,014	5.6%
Income on Investments		1,502,066			1,052,259	
Operating Gain for the Year		$ 1,810,272			$ 4,959,273	

*The gain of $11,422,153 in subscriptions earned reflects gains in enrollment, which increased by 272,700 during the year.

**The rise of $14,043,326 in claims incurred is attributable to increased exposure from larger enrollment, and to increased incidence, which rose from 304 per 1,000 persons to 328.

***The increase of $977,615 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of $526,042 and an increase of $451,573 in Medical-Surgical Plan direct expenses. Based on subscriptions earned, total operating expense decreased by three tenths of a percent.

Summary of Reserves for Protection of Subscribers

		1969		1968
Reserves at January 1		$ 8,996,816		$4,743,407
Operating Gain or (Loss) for the Year		1,810,292		4,959,273
		$10,807,108		$9,702,680
Plus: Reserve Adjustments				
Non-Admitted Assets	$(80,397)		$(77,808)	
Adj. of Prior Year's Income	181,000		360,000	
Unrealized Capital Gains	(223,418)		150,852	
Claim Reserve	(1,708,000)		690,000	
Distribution of Prior Year's Income	(99,800)		(179,000)	
Group Contract Settlement	(294,081)	(2,224,696)	(269,908)	(705,864)
Reserves at December 31		$ 8,582,412		$8,996,816

The decrease of $414,404 in reserves for the protection of Plan Subscribers is due to a net operating gain of $1,810,292 and reserve adjustments totaling $(2,224,696).

New Jersey Participating and Non-Participating Physicians by County—Basic Program

County	Total Elig. Phys.	PARTICIPATING						NON-PARTICIPATING						% P.P. as of 12-31-69	% P.P. as of 12-31-68
		Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.	Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.		
Atlantic	262	244	201	15	13	7	8	18	13	1	—	—	4	93.1	90.6
Bergen	1242	728	572	66	33	16	41	514	450	12	3	1	48	58.6	56.6
Burlington	267	238	177	37	10	2	12	29	19	3	—	—	7	89.1	87.9
Camden	701	615	381	166	33	6	29	86	73	5	2	—	6	87.7	86.4
Cape May	70	64	45	9	3	2	5	6	4	2	—	—	—	91.4	91.3
Cumberland	131	122	101	6	6	3	6	9	6	1	—	—	2	93.1	94.4
Essex	1739	1361	1205	45	65	15	31	378	315	9	2	5	47	78.2	78.6
Gloucester	162	145	89	32	9	3	12	17	14	2	—	—	1	89.5	84.9
Hudson	766	632	553	12	35	7	25	134	117	1	2	1	13	82.5	82.4
Hunterdon	64	60	58	—	—	—	2	4	3	—	—	—	1	93.7	89.2
Mercer	528	430	384	14	16	5	11	98	80	5	—	—	13	81.4	80.2
Middlesex	572	420	368	16	14	8	14	152	119	1	2	3	27	73.4	73.4
Monmouth	551	398	342	18	14	3	21	153	125	4	4	—	22	72.2	69.5
Morris	505	396	325	31	8	8	24	109	77	3	2	—	27	78.4	79.5
Ocean	192	131	106	13	6	1	5	61	47	2	1	1	10	68.2	65.8
Passaic	687	484	401	31	29	6	17	203	164	2	2	1	34	70.4	70.3
Salem	57	53	41	7	2	1	2	4	3	1	—	—	—	92.9	92.9
Somerset	221	177	163	5	3	1	5	44	32	1	1	1	9	80.0	75.4
Sussex	68	62	48	6	1	1	6	6	5	—	—	—	1	91.2	91.9
Union	868	596	477	54	39	7	19	272	233	4	1	1	33	68.6	66.1
Warren	49	45	42	1	—	2	—	4	3	—	—	—	1	91.8	97.7
Out of State	267	241	210	26	3	1	1	26	26	—	—	—	—	90.3	89.0
Total	9969	7642	6289	610	342	105	296	2327	1928	59	20	14	306	76.6	75.7

New Jersey Participating and Non-Participating Physicians by Specialty—Basic Program

Specialty															
Anes.	411	199	183	16				212	206	6				48.4	44.4
Derm. Syph.	160	114	114					46	46					71.2	75.1
Int. Med.	1333	1005	979	26				328	327	1				75.4	75.7
Neur. Surg.	57	31	30	1				26	26					54.4	48.1
Obst. Gyn.	719	519	507	12				200	198	2				72.2	53.0
Ophth.	296	191	189	2				105	105					64.5	63.9
Orth. Surg.	279	177	171	6				102	102					63.4	61.2
Otol.	192	122	117	5				70	69	1				63.5	63.4
Path.	170	145	141	4				25	24	1				85.3	84.1
Ped.	504	446	442	4				58	58					88.5	88.9
Phys. Med.	21	17	16	1				4	4					80.9	80.0
Plast. Surg.	42	12	10	2				30	30					28.6	27.2
Analy. Labs.	119	105				105		14				14		88.2	89.9
Proct.	39	24	17	7				15	15					61.5	61.5
Psy. & Neuro.	413	290	286	4				123	123					70.2	69.2
Radiology	259	196	188	8				63	63					75.6	76.6
Surg.	889	676	654	22				213	211	2				76.0	74.9
Thor. Surg.	37	26	26					11	11					70.3	68.7
Urol.	200	103	100	3				97	97					51.5	51.3
Chiropody	362	342			342			20			20			94.4	94.9
General	2865	2606	2119	487				259	213	46				90.9	90.5
Dentists	602	296					296	306					306	49.2	54.8
Total	9969	7642	6289	610	342	105	296	2327	1928	59	20	14	306	76.6	75.7

New Jersey Participating and Non-Participating Physicians by County—Prevailing Fee

County	Total Elig. Phys.	PARTICIPATING						NON-PARTICIPATING						% P.P. as of 12-31-69	% P.P. as of 5-21-69
		Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.	Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.		
Atlantic	262	184	153	12	9	6	4	78	61	4	4	1	8	70.2	65.3
Bergen	1242	530	434	48	25	9	14	712	588	30	11	8	75	42.6	38.8
Burlington	267	164	126	26	9	2	1	103	70	14	1	—	18	61.4	58.7
Camden	701	440	287	109	24	6	14	261	167	62	11	—	21	62.7	57.4
Cape May	70	35	28	4	3	—	—	35	21	7	—	2	5	50.0	49.9
Cumberland	131	95	81	3	5	3	3	36	26	4	1	—	5	72.5	66.9
Essex	1739	1026	919	34	47	10	16	713	601	20	20	10	62	58.9	55.7
Gloucester	162	96	56	27	8	2	3	66	47	7	1	1	10	59.2	60.1
Hudson	766	479	428	13	25	5	8	287	242	—	12	3	30	62.5	54.4
Hunterdon	64	40	39	—	—	—	1	24	22	—	—	—	2	62.5	57.8
Mercer	528	354	316	11	13	4	10	174	148	8	3	1	14	67.0	61.8
Middlesex	572	309	264	15	13	6	11	263	223	2	3	5	30	54.0	51.3
Monmouth	551	301	269	13	9	2	8	250	198	9	7	1	35	54.6	47.5
Morris	505	304	261	19	8	6	7	201	138	15	2	2	44	60.2	53.3
Ocean	192	75	63	9	2	—	1	117	90	6	5	2	14	39.0	36.6
Passaic	687	385	333	22	20	3	7	302	232	11	11	4	44	56.0	51.1
Salem	57	38	29	4	2	1	2	19	15	4	—	—	—	66.6	66.6
Somerset	221	121	111	4	3	1	2	100	84	2	1	1	12	54.7	55.7
Sussex	68	44	37	3	1	—	3	24	16	3	—	1	4	64.7	61.2
Union	868	459	376	40	30	5	8	334	334	18	10	3	44	52.8	50.5
Warren	49	40	38	1	—	1	—	9	7	—	—	1	1	81.6	71.4
Out of State	267	115	99	13	2	—	1	152	137	13	1	1	—	43.0	41.5
Total	9969	5634	4750	430	258	72	124	4335	3467	239	104	47	478	56.5	52.3

New Jersey Participating and Non-Participating Physicians by Specialty—Prevailing Fee

Specialty															
Anes.	411	183	171	12				228	218	10				44.5	39.3
Derm. Syph.	160	90	90	—				70	70					56.2	52.2
Int. Med.	1333	839	818	21				494	488	6				62.9	58.7
Neur. Surg.	57	26	26					31	30	1				45.6	41.8
Obst. Gyn.	719	460	451	9				259	254	5				63.9	57.8
Ophth.	296	155	153	2				141	141					52.3	48.6
Orth. Surg.	279	128	123	5				151	150	1				45.8	41.3
Otol.	192	109	105	4				83	81	2				56.7	52.1
Path.	170	81	80	1				89	85	4				47.6	38.9
Ped.	504	336	333	3				168	167	1				66.6	62.3
Phys. Med.	21	12	11	1				9	9					57.1	54.5
Plast. Surg.	42	9	8	1				33	32	1				21.4	18.9
Analy. Labs.	119	72				72		47				47		60.5	57.0
Proct.	39	25	21	4				14	11	3				64.1	58.9
Psy. & Neuro.	413	238	236	2				175	173	2				57.6	53.5
Radiology	259	133	128	5				126	123	3				51.3	45.6
Surg.	889	523	510	13				366	355	11				58.8	53.3
Thor. Surg.	37	24	24					13	13					64.8	59.3
Urol.	200	109	108	1				91	89	2				54.5	49.4
Chiropody	362	258	—	—	258			104	—	—	104			71.2	67.6
General	2865	1700	1354	346				1165	978	187				59.3	54.8
Dentists	602	124					124	478					478	20.6	20.7
Total	9969	5634	4750	430	258	72	124	4335	3467	239	104	47	478	56.5	52.3

OFFICERS

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Joseph P. Donnelly, M.D., President

John S. Robinson
Executive Vice President

Jerome C. Rothgesser, M.D.
Vice President-Medical Affairs
And Medical Director

William R. Skelly
Secretary-Treasurer

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Jerome G. Kaufman, M.D. (1970)

Second Vice President
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Morgan Sweeney (1972)
Charles O. Tyler, M.D. (1971)
Stanley C. Van Ness, Esq. (1970)
Robert E. Verdon, M.D. (1972)

TRUSTEES EMERITUS

	Appointed	*Term as Board Member*
Edward W. Sprague, M.D.	1966	1942-1966
John S. Thompson	1966	1942-1965

ADVISORS TO THE BOARD OF TRUSTEES

	Appointed	*Term as Board Member*
William F. Costello, M.D.	1958	1948-1958
William E. Dodd, M.D.	1952	1944-1952

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.
1945-1945
*Charles W. Barkhorn, M.D.
1952-1965
Irving P. Borsher, M.D.
1950-1965
*F. Clyde Bowers, M.D.
1961-1963
*Theophilus H. Boysen, M.D.
1944-1945
Lewis W. Brown, M.D.
1949-1954
*William J. Carrington, M.D.
1942-1943
*Harry N. Comando, M.D.
1942-1958
*Samuel A. Cosgrove, M.D.
1944-1953
Joseph P. Donnelly, M.D.
1953-1968
*William K. Harryman, M.D.
1944-1945
Sigurd W. Johnsen, M.D.
1942-1948
*Augustus S. Knight, M.D.
1942-1948
*Thomas K. Lewis, M.D.
1942-1949
*Arthur W. Lunn
1951-1962
Paul Mecray, Jr., M.D.
1953-1961
Duane E. Minard, Jr.
1957-1965
Glennis S. Rickert, M.D.
1959-1963
*Royal A. Schaaf, M.D.
1942-1964
*Norman M. Scott, M.D.
1942-1950
Reuben L. Sharp, M.D.
1950-1952
James J. Spencer, M.D.
1957-1961
Gustave E. Wiedenmayer
1961-1966
*Carl K. Withers
1952-1961
David L. Yunich
1962-1963

*Deceased

Approved (page 431)

JEMPAC

Marshall F. Driggs, M.D., Chairman, Englewood

(Report to the House of Delegates)

This is the seventh year in New Jersey and the ninth nationally that medicine has met the challenge of Labor's "Committee on Political Education" (COPE) by expressing its views in the political arena. This has been done by ethical, legal, and over 65% successful political education and action programs aimed at getting into office men who share the philosophy of organized medicine as to government's appropriate role in the delivery of superior care to the people. Up to now this has been primarily directed at the House of Representatives level, but there has now developed involvement with candidates in state offices; and those of you who attend our Monday morning (7:30 a.m.—Pennsylvania Room No. 2 Annual Breakfast), will hear from an eloquent U. S. Senator friend of organized medicine, who will tell us of his gratitude for the critical role played in his own election campaign by the money and other activities of physicians and their wives.

Since the passage of Medicare the progression of government influence in health care delivery has become more apparent. As the role of government expands in health services, it is the feeling of JEMPAC that the physician must maintain his strong role of control and influence in programs at national or state levels where the delivery of health care services is involved. We must re-evaluate and re-emphasize such phrases as that which is found in the Medicare law (P. L. 89-97; section 1801: "Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided".)

This House is well aware of the inspiring and visionary efforts of Byron Blaisdell, in serving so conscientiously as our JEMPAC Chairman for a period of over six years. His efforts laid the groundwork for a strong New Jersey Medical Political Action Committee. I am sure that all members of the MSNJ will join those of JEMPAC in our expression of gratitude to him. In a recent unanimous vote, the Board of Directors of JEMPAC made him a life-time honorary JEMPAC member.

Our Committee is now for the first time using a new technique of membership solicitation, which has proved itself in the 42 other states where it is being utilized as being eminently successful. This is called voluntary non tax-deductible, joint billing and involves the same billhead, with JEMPAC listing, as part of the annual bill for county societies, state associations and the A. M. A. dues. Already in recent months Monmouth, Bergen, Burlington, and Union counties have instituted joint billing in their areas. It is the hope of the JEMPAC Board to encourage acceptance of this important technique in all 21 of the New Jersey component county medical societies. The JEMPAC members and Board are appreciative of the action by MSNJ Board of Trustees, Executive Director, and Legal Counsel in thoroughly studying and supporting the legality of this technique in our state last year. In the past few months our membership roster, as a result of this development, has markedly grown. It is the hope of our Board that New Jersey may soon, through physician membership, enthusiasm, and growing involvement, pull itself up from the bottom of the AMPAC ladder to a more respectable position nearer the top.

Around us we see impressive evidence of activists, many of them from the dissident young, changing from disorganized revolt to a more effectual political activity in their own local areas. Can we, as practitioners of a learned profession, allow ourselves to be less intelligent and less active than they in making our strong convictions known where we

live, and where we attempt to be recognized and respected citizens of the country we love. Should we not, as physicians, resolve, in these important times, to put our own appropriate amount of time, money, and dedication to the achievement of those goals we hold so dear.

To quote Pericles, this learned statesman, prior to 400 B. C., stated: "We do not allow absorbtion in our own affairs to interfere with participation in the city's; we regard him who holds aloof from public affairs as useless."

Received as informative

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1970 annual meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Atlantic County

Richard C. Bew, Northfield; Age 63
Irving C. Shavelson, Margate City; Age 65
Royal E. Durham, Ventnor City; Age 76

Bergen County

Willard H. Lemmerz, Wood Ridge; Age 62
Maurice M. Lynch. Hackensack; Age 69
Ralph P. McFeeley, Hackensack; Age 79
A. Donald McLane, Delray Beach, Fla. (formerly Englewood); Age 67
Vincent Pelligrini, Bolton Landing, N. Y. (formerly Paramus); Age 60
Marie J. Singer, Castle Point, N. Y. (formerly Dumont) ; Age 53
Frank S. White, Teaneck; Age 65

Cumberland County

Horace J. Ettinger, Vineland; Age 77

Essex County

William A. Berger, Newark; Age 67
Abraham G. Chmelnik, Newark; Age 71
David P. Cooper, East Orange; Age 59
Joseph D. Cuono, West Caldwell; Age 58
Olindo Del Guercio, Newark; Age 71
John A. DeVivo, South Orange; Age 62
William B. Ein, East Orange; Age 70
William F. Grant, Newark; Age 70
Mildred G. Gregory, West Orange; Age 70
Marcus H. Greifinger, South Orange; Age 70
Fred A. Hasney, Sparta; Age 68
Harry Horn, Orange; Age 70
John J. Lee, Orange; Age 74
Elwood H. MacPherson, Millburn; Age 73
Pasquale E. Nappi, Newark; Age 67
Vera Schectman, Miami Beach, Fla. (formerly Newark); Age 80
John J. Shaw, Orange; Age 63
Robert G. Stewart, Montclair; Age 75
Leonard Tushnet, Maplewood; Age 62

Gloucester County

Dorothy M. Rogers, Woodbury; Age 72

Hudson County

Frederick Finger, Bayonne; Age 68
Joseph D. Goldstein, Silver Spring, Md. (formerly Jersey City; Age 62
Louis F. Harter, Pompano Beach, Fla. (formerly Jersey City) ; Age 71

Mercer County

Jonathan Howland, Mexico (formerly Lawrenceville); Age 52

Middlesex County

Henry T. Weiner, New Brunswick; Age 62

Monmouth County

C. Byron Blaisdell, Long Branch; Age 72

Morris County

Edgar J. Evans, Jr., Denville; Age 61

Passaic County

Sidney S. Brooks, Bay Harbor Island, Fla. (formerly Paterson); Age 72
Samuel Fisher, Fort Lee; Age 65
Wilbert Sachs, Coral Gables, Fla. (formerly Passaic); Age 70

Union County

Arthur F. Ackerman, Summit; Age 66
Thomas R. Austin, Cranford; Age 68
Mildred T. Bohne, Summit; Age 53
Robert P. Boyd, Fanwood; Age 65
Cedric C. Carpenter, Summit; Age 64
Harold Goldfield, Elizabeth; Age 68
Charles A. Hoffman, Plainfield; Age 72
Henry J. Konzelmann, Sea Girt; Age 65
Frederic W. Lathrop, Sr., Plainfield; Age 71
Edward T. Lynch, Elizabeth; Age 65
Alexander Strelinger, Elizabeth; Age 70
Nathan F. Vogel, Springfield; Age 60
Herman H. Zeitlin, Linden; Age 67

Warren County

George E. Michell, Hackettstown; Age 70

Approved (page 442)

MEMORIAL RESOLUTION

The following memorial resolution was received by the House with sorrowful concurrence.

Lloyd A. Hamilton, M.D.
1896-1969

Whereas, the late-lamented Lloyd A. Hamilton, M.D., was a faithful member of The Medical Society of New Jersey since 1936 and served three consecutive terms as a valued member of its Board of Trustees: and

Whereas, as a member of the State Board of Medical Examiners from 1964 to 1969, he rendered sustained service to the medical profession and the people of New Jersey; and

Whereas, in his practice and throughout his life he consistently exemplified the exalted qualities of mind and heart which typify the highest standards of professional and personal conduct; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey records profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting, and another copy, suitably prepared, be presented to his bereaved family.

RESOLUTIONS

#1

Support of All Programs of Nursing Education

From the Board of Trustees

(Reference Committee "A")

Whereas, in New Jersey in 1968 the hospital schools of nursing graduated 84% of the total of graduates from all programs of nursing education in the State, accounting for 1,241 graduates out of the all-programs total of 1,476; and

Whereas, experience has demonstrated that hospital schools of nursing present programs adequately balanced in academic and clinical components which produce professional nurses of high competence; and

Whereas, the American Nurses Association has adopted a policy position which advocates that public support and funding be limited only to degree-granting programs of nursing education; and

Whereas, such a policy would unjustly and indefensibly disregard hospital schools of nursing as the prime and proven source of professional nurses, with great disservice to the public and the health care professions; now therefore be it

RESOLVED, that The Medical Society of New Jersey affirm its approval and support of all programs of nurse education—baccalaureate, associate degree, hospital diploma, and practical; and be it further

RESOLVED, that The Medical Society of New Jersey urge the Governor, the members of the legislature, and the general public to encourage, expand, and financially support all such programs as critically necessary for the delivery of adequate nursing services to the people of New Jersey.

Adopted (page 429)

#2

Assimilation of Osteopaths

From the Essex County Medical Society

(Reference Committee "A")

Whereas, the American Medical Association's House of Delegates in July, 1969, amended AMA Bylaws so that qualified Doctors of Osteopathy may be admitted to full active membership in the American Medical Association; and

Whereas, this was done to assure the provision of the best possible health care to the American people and make available to

osteopathic students and graduates education of the same high standards as prevail in undergraduate, graduate, and continuing medical education programs; and

Whereas, the AMA House of Delegates suggested that "each county and state medical society may accept qualified osteopaths as active members and thereby provide for their membership in the American Medical Association"; and

Whereas, the AMA House of Delegates suggested that state and county societies and other affected organizations "May proceed to make such constitution and bylaw changes as are necessary to implement the foregoing"; therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey instruct the Committee on Revision of Constitution and Bylaws to prepare suitable amendments for presentation at next year's annual convention to permit those Doctors of Osteopathy who are fully licensed to practice medicine and surgery to become members.

Not adopted, in view of the action approving the report and recommendation of the Committee on Admission of Osteopaths to MSNJ Membership (page 429)

#3

Establishment of Office of Professional Medicare Liaison within Prudential Insurance Company

From the Morris County Medical Society

(Reference Committee "A")

Whereas, the medical profession is primarily concerned with the health care of the country; and

Whereas, the costs of health care are frequently assumed by third party carriers; and

Whereas, it has been found to be in the best interest of the community for the medical profession to have a method of close liaison with these insurance carriers; and

Whereas, there has been failure of a liaison with the Medicare carrier (Prudential Insurance Company of America) because of no professional office or person who can be easily called upon for direct aid and assistance; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge and use its facilities to bring about the establishment of an Office of Medicare Liaison within the Prudential Insurance Company.

Adopted (page 429)

#4
Statewide Automated Bookkeeping, Accounting, and Billing System

From the Essex County Medical Society

(Reference Committee "B")

Whereas, medical societies in the State of New Jersey have not adopted modern, automated business methods in their bookkeeping, accounting and billing systems; and

Whereas, most businesses which collect and disburse large amounts of monies have already converted their systems; and

Whereas, account systems with which we deal, such as those of the AMA and the Hospital Service Plan of New Jersey are automated; and

Whereas, it is becoming increasingly difficult to deal with an automated system when you are using double entry, outmoded card file systems and typed lists of members; and

Whereas, the initial conversion is expensive, but through the years the accounting and billing cost per member at both the county and state level would be greatly reduced; and

Whereas, other membership information could be put on computer cards for use in printing membership directories and specialized mailings, etc.; and

Whereas, no county society is large enough to justify its own system independent of the State Society, and an automated county society could not deal with the computers of the AMA going through a State Society which was not automated; and

Whereas, members could receive dues and Blue Cross billings in much the same manner as they now receive telephone bills, with a punch card to return for proper credit; and

Whereas, other state societies have done this and provided computer services to county components; and

Whereas, automated systems are no longer a luxury when dealing with eight thousand members; now therefore be it

RESOLVED, that The Medical Society of New Jersey investigate and establish an automated modern system of bookkeeping, accounting and billing and make the advantages of such system available to all component medical societies on a fair basis of cost.

"Resolved" amended by the House to Read:

RESOLVED, that The Medical Society of New Jersey investigate an automated modern system of bookkeeping, accounting, and billing and make the advantages of such system available to all component medical societies on a fair basis of cost, if found feasible; and that the Board of Trustees be empowered to put such automated system into effect.

Adopted as amended by the House (page 430)

Procedural Terminology Useful In Settling Claims

The newly published second edition of the Current Procedural Terminology (CPT) is now available as an aid in settling claims for compensation through insurance companies or Medicare and Medicaid. This is a uniform system of terminology and coding which provides a method to describe diagnostic or therapeutic procedures.

CPT is priced at $2 (less 50 per cent discount on medical society orders). Write to the American Medical Association, 535 North Dearborn Street, Chicago 60610. Checks must accompany orders.

#5

Mobile Coronary Care Unit

From the Essex County Medical Society

(Reference Committee "D")

Whereas, there has been a recent abundance of articles and editorials in national medical publications favoring mobile cardiology care rescue units and ambulances and a program of training, accreditation, and licensing for medical assistants to ease the shortage of personnel capable of giving emergency treatment to carry out emergency procedures now considered "medical practice"; and

Whereas, the Essex County Medical Society considers that the crux of the matter involves three points: 1) The recognized time lapse between the patient's reported attack and subsequent adequate hospital care; 2) The emergency methods and procedures at the scene of the attack which would substantially improve survival rates; 3) The possibility of adequately training non-physicians to utilize these methods and procedures; and

Whereas, the Essex County Medical Society agrees that a mobile cardiology unit with carefully selected, well trained, intelligent, properly motivated personnel could save lives; and

Whereas, the Cardiology Committee of the Essex County Medical Society unanimously agreed that the use of emergency cardiac drugs is every bit as important as the use of the defibrillator in providing adequate ambulance-unit care, in order to stabilize the patient prior to rushing him to the hospital for care; and

Whereas, the Essex County Medical Society unanimously agreed that a definition of what constitutes adequate training for paramedical personnel must be prepared, and that this should come from the American College of Cardiology or the U. S. Public Health Service or a medical school, rather than from a medical society's cardiology committee; now therefore be it

RESOLVED, that The Medical Society of New Jersey take the initiative and exercise leadership in this area of vital importance and cause legislation to be introduced which would permit adequately trained, paramedical, mobile unit personnel to institute proper emergency cardiac procedures, in order to save the lives of more patients between the time of attack and their being transported to the hospital; and be it further

RESOLVED, that inasmuch as first-aid and rescue-squad personnel in many areas are the principal people to respond—and in some areas the only personnel who can respond—within minutes to an emergency situation, that steps be taken adequately to train them and to permit them legally to utilize all modalities available for mobile unit coronary care.

Not adopted (page 432)

AMA Offers Sex Education Films

"A Look at Sex Education in the Schools" is now available on 16 mm film. It is in color and runs for 28 minutes. Here presented is an interesting up-to-date analysis of the considerations in the implementation of the AMA resolution endorsing family life and sex education programs in the nation's schools.

Prints are available without charge, on loan, to medical societies and women's auxiliaries from the AMA Radio and TV Department, 535 North Dearborn Street, Chicago 60610.

#6

Proposed National Academy of the Health Professions for Research and Policy

From the Essex County Medieal Society

(Reference Committee "D")

Whereas, the Himler Report on pages 54, 55, 56, and 57 discusses the possible formation of a "National Academy of the Health Professions For Research and Policy"; and

Whereas, the formation of such an academy is a consideration for the future which deserves to be studied in detail with a careful weighing of its merits, disadvantages and most acceptable structure; and

Whereas, it is noted that the already suggested structure omits participation by clergy; and

Whereas, the clergy, who work closely with physicians in total patient care, as described in the AMA brochure on medicine and religion entitled "The Physician, the Clergy, and the Whole Man" deserve representation; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge that any structure considered for such "National Academy of Health Professions For Research and Policy" include representatives of hospital chaplains.

Adopted (page 432)

#7

Immunity for Physicians Volunteering Their Services in State Medical Programs

From the Burlington County Medical Society

(Reference Committee "E")

Whereas, the New Jersey State Department of Health has, from time to time, recommended, endorsed, and requested various health programs involving mass diagnostic, preventive and therapeutic programs which are in the public interest in the effort to eliminate disease and other health hazards; and

Whereas, these programs require the participation of volunteer physicians in order to implement them; and

Whereas, such participation by physicians increases their exposure to civil damages in the event of possible malpractice action; and

Whereas, such liability may cause physicians to refrain from volunteering their professional services for causes which are deemed to be in the public interest; and

Whereas, such additional exposure to liability may cause already exorbitant malpractice in-

surance premiums to be increased still further; now therefore, be it

RESOLVED, that The Medical Society of New Jersey seek enactment of State legislation which would provide The Medical Society of New Jersey, its component county medical societies and individual physicians with immunity from litigation which may arise from the rendering of professional services voluntarily in any diagnostic, preventive, or therapeutic health program recommended, endorsed, or requested by the New Jersey State Department of Health.

Reference Committee amended the foregoing paragraph to read:

RESOLVED, that The Medical Society of New Jersey request the Governor and the State Department of Health to seek enactment of State legislation which would provide licensed physicians and their professional societies with immunity from litigation which may arise from the rendering of professional services voluntarily in any diagnostic, preventive, or therapeutic health program recommended, endorsed, or requested by the New Jersey State Department of Health.

Adopted as amended by the Reference Committee (page 434)

#8

Compensation of Physicians Under Medicare and Medicaid

From the Cumberland County Medical Society

(Reference Committee "E")

Whereas, present bases of compensation under Medicare and Medicaid include considerations of regions of practice and other criteria that make for inequities of payment to physicians throughout the State; now therefore be it

RESOLVED, that uniform fees be established for Medicare-Medicaid services on an equal basis for all doctors of medicine in all parts or counties of the State of New Jersey.

Not adopted, because it is in contravention of official policy established by the House of Delegates (page 434)

A Million To Medical Schools

Contributions for the support of medical education, made during 1969, and distributed to individual schools this spring, totaled $956,909. The funds were collected and allotted by the American Medical Association Education and Research Foundation. Recipients were 109 U.S. and nine Canadian schools. The grants to Canadian schools were specifically earmarked for them by donors.

Checks designated for each of the schools were mailed March 9 to secretaries of state medical associations for presentation to the deans. Almost equal-sum grants from undesignated funds were made to each school, but earmarked contributions totaled $721,939.

Receiving the largest total grants were: University of Illinois College of Medicine, $29,291; Indiana University School of Medicine, $28,861; Northwestern University Medical School, $28,754; University of Maryland School of Medicine, $25,401; and University of Tennessee College of Medicine, $23,820.

#9

Legislative Approach to Malpractice

From the Essex County Medical Society

(Reference Committee "E")

Whereas, we as physicians have realized that the number of unjustifiable professional liability suits has been rapidly increasing causing yearly jumps in premiums; and

Whereas, a Senate Subcommittee recently viewed the increased malpractice suits and higher judgments as a situation which, "threatens to become a national crisis with patients having to pay more for medical services"; and

Whereas, liability laws are governed by state legislation; and

Whereas, medical societies in California, Alaska, and Oregon have shown us that state legislation can be changed to help reverse the present unfavorable legal climate towards physicians; and

Whereas, the AMA has officially recommended that medical societies and physicians work toward obtaining more favorable liability laws through state legislators; now therefore be it

RESOLVED, that The Medical Society of New Jersey establish a small special committee to work with legislators with the goal of introducing and working toward achieving legislation along the following lines:

(1) that if a liability case goes to court and the plaintiff loses, the law require that he pay all expenses, both his own and those of the defendant physician; and

(2) that we attempt to establish through legislation maximum payment for any malpractice case. (Establishment of statutory ceilings on the damages that may be awarded for various kinds of injury or disability, or if a physician is working in a non-profit hospital or institution which has a maximum liability that he also be provided with this maximum liability protection.); and

(3) extend concept of privileged communications to the proceedings, and/or records of medical review committees of local medical societies and staff committees in hospitals; and

(4) there shall be no monetary liability on part of, and no cause for action for damages shall arise against, any member of a duly appointed committee of state or local professional society, or duly appointed member of a committee of a medical staff of a licensed hospital, provided that they are operating pursuant to written and duly adopted by-laws; and

(5) require the court upon motion of either party to proceed to a separate trial of the defense of the Statute of Limitations before any other issue if the case is tried, if in an action against a physician or surgeon, the answer pleads that the action is barred by the Statute of Limitations.

(6) require that the jury be instructed that plaintiff has burden of proving defendant's negligence, by a preponderance of evidence, and that injury alone does not raise either a presumption or inference of negligence; and

(7) to specifically provide immunity to members of cardiac resuscitation teams; and

(8) to provide a good faith provision for emergency medical care for complications arising from prior care furnished by others; and

(9) to permit defendant to file a motion requiring plaintiffs in malpractice actions to file

a cost bond of not more than $500 if there is a showing the claim is frivolous; and

(10) to request the legislation to establish a maximum period of seven years from date of treatment of a minor within which an action to recover damages for personal injuries resulting from medical treatment or omissions must be filed; and

(11) legislation to abrogate *res ipsa loquitur* in malpractice cases; and

(12) legislation to require casualty insurance companies providing other liability lines to be required to insure medical malpractice at reasonable premium rates as a condition for doing business in the State; and

(13) the introduction of a bill to lessen the number of actions based upon the theory of lack of informed consent; and

(14) legislation to provide for the downward gradation of contingent legal fees in malpractice cases to replace the present practices of plaintiff's attorneys charging a flat percentage regardless of the settlement or award; and be it further

RESOLVED, that this special committee be prepared to meet at the convenience of New Jersey Legislators to fully explain the import of each separate bill introduced.

Approved in principle and referred to Joint Committee of Council on Legislation and Committee on Medical Defense and Insurance (page 434)

#10

Opposition to the Legalization of Marihuana

From the Essex County Medical Society

(Reference Committee "E")

Whereas, marihuana — known variously as "grass," "weed," "pot," etc.—is not a harmless or innocuous drug; and

Whereas, its use may precipitate intoxication characterized by excitement, mental confusion, disorientation, hallucinations, euphoria, depression, suicidal impulses, and the like; and

Whereas, its continued use may contribute to a loss of individual goals and ambitions, or evasion of and/or withdrawal from reality and the pursuit of illusory goals; and

Whereas, its widespread use by our youth as a means of coping with daily stresses of life is a cause of concern; and

Foregoing "whereas" amended by the Reference Committee to read:

Whereas, its widespread use as a means of coping with daily stresses of life is a cause of concern; and

Whereas, it is being prepared in increasingly concentrated forms, be it

RESOLVED, that The Medical Society of New Jersey affirm to the public that marihuana is a dangerous drug; and be it further

RESOLVED, that the Society assume leadership in advising the public that it is against changes in the laws related to the illicit sale or smuggling of the drug for sale purposes; and be it further

Foregoing "resolved" amended by the Reference Committee to read:

RESOLVED, that the Society assume leadership in advising the public that it is against relaxing laws related to the illicit sale or smuggling of the drug for sale purposes; and be it further

RESOLVED, that the Society clearly state its opposition to the legalization of marihuana; and be it further

RESOLVED, that The Medical Society of New Jersey cause a similar resolution to be introduced in the House of Delegates of the American Medical Association and direct the New Jersey Delegates to the American Medical Association to support these objectives.

Adopted as amended by the Reference Committee (page 434)

#11

Temporary Licensure of Certain Foreign Physicians

From the Hudson County Medical Society

(Reference Committee "E")

Whereas, there is a critical shortage of physicians in New Jersey to adequately meet the needs of the community; and

Whereas, most of the hospitals of New Jersey are having difficulty in filling their internships and residencies with physicians trained in the United States; and

Whereas, many of these interns and residents are graduates of foreign medical schools who are in this country on temporary visas and intend to return to their home countries; and

Whereas, these foreign graduates after their internships and residencies are often available to cover various departments of the hospitals serving as house physicians and surgeons in hospitals with or without an intern or residency program; and

Whereas, under the existing Medical Practice Act of New Jersey these qualified and well-trained physicians cannot be employed unless licensed in the State of New Jersey; therefore be it

RESOLVED, that in order to allow the hospitals of New Jersey to better care for their patients, the Medical Practice Act be amended to permit the State Board of Medical Examiners to grant temporaty licenses to eligible (as defined hereunder) physicians to work only in licensed hospitals and only under supervision of licensed physicians . . .

"Eligible physicians shall be those physicians who have completed an internship (or residency) in a hospital in the United States which has been approved by the Education Council of the American Medical Association (or Osteopathic Association) and have passed the ECFMG examination."

and; be it further

RESOLVED, that temporary licensure shall be granted annually to any such eligible

physician for not more than a total of three years and only with the proof of his continued employment in a hospital licensed by the State of New Jersey.

With the approval of the sponsor, the Reference Committee offered the following substitute resolution for Resolution #11:

Whereas, there is a critical shortage of physicians in New Jersey adequately to meet the needs of the community; and

Whereas, most of the hospitals of New Jersey are having difficulty in filling their internships and residencies with physicians trained in the United States; and

Whereas, many of these interns and residents are graduates of foreign medical schools who are in this country on temporary visas and intend to return to their home countries; and

Whereas, these foreign graduates, having completed their internships and residencies, are often available to serve as house physicians and surgeons in hospitals with or without an intern or residency program; and

Whereas, under the Medical Practice Act of New Jersey these qualified and well-trained physicians cannot be employed unless licensed by the State of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey vigorously seek the enactment of legislation to exempt eligible physicians (as defined hereunder) from the prohibitory provisions of the Medical Practice Act while they are in the employ of a hospital licensed by the State of New Jersey. No physician shall be granted this exemption for longer than a period of three years.

"Eligible physicians shall be those physicians who have completed an internship or residency in a hospital in the United States which has been approved by the Education Council of the American Medical Association (or American Osteopathic Association)."

Not adopted (page 434)

#12

Medicare Billing Forms

From the Hudson County Medical Society

(Reference Committee "E")

Whereas, the Prudential Insurance Company has changed the original Medicare billing form; and

Whereas, the new form is confusing to the patient; and

Whereas, it is noted that this new form does not indicate the amount the patient is responsible for as it formerly did; therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as favoring a change in the Medicare form to include the amount due the physician by the patient and said amount be clearly indicated as in the original form.

Adopted (page 435)

#13
Separate Department of Mental Health and Mental Retardation

From the Morris County Medical Society

(Reference Committee "F")

Whereas, the Morris County Medical Society wholly concurred with the 1968 Resolution #14, as amended; and

Whereas, Reference Committee "G" of that year, recommended that the House of Delegates adopt the Resolution, as amended; and

Whereas, the Council on Mental Health, after careful study, has issued a position statement —"that there be a separate Department of Mental Health, with direct access to the high levels of government and medical responsibilities of mental health services in New Jersey" now therefore be it

RESOLVED, that The Medical Society of New Jersey wholly adopt the most recent position statement submitted by the Council on Mental Health, urging a separate Department of Mental Health and Mental Retardation, with a licensed physician as Commissioner thereof.

Amended by the Reference Committee to read:

RESOLVED, that The Medical Society of New Jersey wholly adopt the most recent position statement submitted by its Council on Mental Health, urging a separate Department of Mental Health and Mental Retardation, with a board certified psychiatrist as Commissioner thereof.

Adopted as amended by the Reference Committee (page 439)

#14
Hazards of Air Pollution

From the Essex County Medical Society

(Reference Committee "G")

Whereas, medical evidence is now overwhelming that air pollution seriously affects health; and

Whereas, physicians who know of its health dangers should take the lead in informing the public; and

Whereas, at some future time, the human body may not adapt to an increasingly polluted environment; and

Whereas, media such as press, radio, T.V. and advertising are open to the AMA as spokesman for the profession; and

Whereas, an alerted public will demand effective legislation and control action; now therefore be it

RESOLVED, that The Medical Society of New Jersey submit a resolution to the House of Delegates of the AMA resolving that the AMA initiate a continuing campaign through the public media alerting the American people to the ever-increasing health hazards of air pollution and to the urgent need for more research and effective control measures.

Adopted (page 441)

#15

MSNJ Convention Format

From the Essex County Medical Society

(Reference Committee "H")

Whereas, the present format of the annual convention of The Medical Society of New Jersey is unduly long and shows little consideration for the valued time of busy professional men; and

Whereas, scientific sessions have often overlapped with required attendance at delegate sessions so that important speakers have been left to address a few physicians and delegates have not been able to attend educational lectures of their choice; and

Whereas, all reference committees are held at the same time and a delegate or member interested in speaking at more than one cannot do so; now therefore be it

RESOLVED, that the MSNJ convention format be changed to permit members to speak to more issues, vote on issues without waiting around unnecessary days, attend scientific sessions of their choice which do not overlap business sessions; and be it further

RESOLVED, that in drafting such format the utmost consideration be given to conserving the members' time; and be it further

RESOLVED, that the following format which has worked well for some other medical organizations be given fair appraisal:

Saturday Morning—Reports of Officers and Committees

Saturday Afternoon—Half of the Reference Committees meet (most important, topical, or paramount issues go to this day's reference committees).

Sunday Morning—Remainder or 2nd half of Reference Committees meet.

Sunday Afternoon—Delegate Session to vote on reference committee reports of committees which met Saturday afternoon.

Monday Morning—Delegate Session—vote on remainder of reference committee reports—those who met Sunday morning and hold election of officers.

Monday Afternoon—Delegate Sessions ended and Scientific Programs begin.

Not adopted, referred to the Committee on Annual Meeting (page 442)

New Anti-Smoking Display Posters

Two new colorful, illustrated posters—one to discourage would-be smokers and the other to encourage the "addicted" to quit—have been produced by the AMA for display in schools, public places, physicians' offices, and wherever smokers and the "tempted" may gather.

The poster for non-smokers carries the message, "Best Time to Stop Smoking . . . Is Before You Start!" and the other shows a crumpled cigarette with the advice, "Break the Habit—The Best Break of Your Life."

Both are 18½ x 22" in two colors. Orders should be addressed to the AMA, 535 North Dearborn Street, Chicago, Illinois 60610. Although each is listed at 20¢ and 18¢ for quantities of 50 to 99, orders received on medical society letterhead will be accorded 50 per cent discount benefit. The serial order number on the "Best Time. . . " poster is OP-247 and "Break the Habit. . . " is OP-251.

#16

Physicians' Welfare Fund

Joseph J. Kline, M.D., Delegate from Mercer County

(Reference Committee "B")

Whereas, a member physician and his family may become indigent because of the catastrophic or protracted illness of the physician; and

Whereas, temporary financial assistance might induce a more speedy rehabilitation of the physician and provide the means for his family to continue to live decently during the period of his convalescence; now therefore be it

RESOLVED, that The Medical Society of New Jersey adopt a special annual per capita membership assessment of two dollars ($2.00) to develop a fund to meet this end; and be it further

RESOLVED, that a committee be appointed by the Board of Trustees to administer this program, such committee to consist of three (3) members, one each from the northern, central, and southern sections of the State; and be it further

RESOLVED, that the committee members serve staggered terms, and that they be chosen and empowered to disburse the funds under their control on the basis of their judgment and compassion.

Not adopted—see Reference Committee notation (page 430)

#17

Medical School Program at Rutgers

From the Somerset County Medical Society

(Reference Committee "E")

Whereas, there is admittedly a serious shortage of physicians in New Jersey and a critical need for the existence within the State of adequate educational facilities to afford citizens of New Jersey the opportunity of pursuing medical studies within its boundaries; and

Whereas, at the present time the school of medicine at Rutgers University offers only a two year program and that to a decidedly limited number of students; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the Governor and the New Jersey Legislature promptly to take all steps necessary to expedite the development of an expanded, full medical school program at Rutgers University including the early construction of the planned Psychiatric Institute.

Substitute Resolution for Resolutions #17, 29, 32

Whereas, The Medical Society of New Jersey has long stressed the fact that New Jersey needs more physicians equipped to deliver medical care to the people of the State; and

Whereas, in consequence, the Society has frequently recorded itself as favoring the establishment of two full medical school programs in North Jersey and one in South Jersey; and

Whereas, to that end it has further recommended that the

New Jersey schools of medicine produce practicing physicians, with emphasis on general practice; and

Whereas, the Governor of New Jersey in his special message to the Legislature an "Education For Better Medical Care" has articuloted o program including o coordinated plan for supervising medical education in our State; and

Whereas, in Assembly Bill 1059, the Governor has coused to be introduced legislation which would move toward accomplishing these ends more efficiently and economically; now therefore be it

RESOLVED, that The Medical Society of New Jersey endorses the message on "Education For Better Medical Care" and records its approval of Assembly Bill 1059; and be it further

RESOLVED, that The Medical Society of New Jersey, assembled in its 1970 Annual Meeting, thraugh its House af Delegates, recommends to the Legislature and Gavernor, the following plan:

1. Maintain and expand the existing full medical programs and facilities at Newark.

2. Maintain the present college of medicine facility at New Brunswick, but enlarge its size to accammadate 100 students per class and expand it to a complete M.D. program as soon as passible.

3. Establish a unified Baard of Trustees to serve the two existing medical schools and the third such school contemplated for Southern Jersey. It is urged that the Board include representatives of the geographic areas in which the schools are located.

4. Consider the possibility of operating each medical schaal on an eleven month instead of the present nine month schedule. In four years this will effect a saving of eight academic manths and may make possible the shortening of the curriculum ta three calendar years.

Substitute Resolutian for Resalutians #17, #29, and #32 adopted as amended by the House (page 435)

#18

New Method for Reporting Maternal Deaths

From Reynold E. Burch, M.D., Delegate from Essex County

(Reference Committee "G")

Whereas, the present system of investigation of maternal deaths is inadequate; and

Whereas, there has been a population increase in the State of New Jersey; and

Whereas, there has been increased hospital construction in the State of New Jersey; and

Whereas, there is considerable time involved in transportation in the securing of information of maternal mortalities; and

Whereas, the present stipend paid to the investigating physician in no way compensates for the amount of time and effort consumed in this pursuit; now therefore be it

RESOLVED, that a physician who is a Diplomate of the American Board of Obstetrics and Gynecology be officially designated by the proper agency of the New Jersey State Department of Health to review the charts and to conduct a complete investigation including interview of all associate parties; and be it further

RESOLVED, that a salary scale paid by the State of New Jersey Department of Health be developed for this position; and be it further

RESOLVED, that a standardized form be developed, designed to secure all relevant and pertinent information regarding maternal mortalities and that this form be circularized among the Maternal Welfare Committee of The Medical Society of New Jersey, and the County Maternal Welfare Committees for additional suggestions and approval; and be it further

RESOLVED, that this entire Resolution be submitted to the New Jersey State Department of Health.

Nat adopted, as unnecessary in view af the actian already taken conjointly by the Department of Health and MSNJ (page 441)

#19

Compensation under Medicaid

From William M. Chase, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, The Medical Society of New Jersey has endorsed the principle of usual and customary fees for services rendered to patients receiving medical benefits under the Medicaid and Medicare Programs; and

Whereas, there is at present a change in this philosophy with respect to Medicare; and

Whereas, the New Jersey Medical Assistance and Health Services Act never implemented the doctrine of usual and customary fees for services; now therefore be it

RESOLVED, that The Medical Society of New Jersey petition the Medicaid Commission to publish a complete fee schedule with full disclosure of the mechanism by which those fees were arrived and how it affects each division of medicine and its specialties; and be it further

RESOLVED, that the Medicaid Commission put in print the criteria and standards to be used by its consultants with respect to authorizations for those medications and services requiring the prior permission of the Medicaid Commission before being prescribed.

The intent of this resolution is to give physicians the right to decide whether they will continue to service Medicaid recipients on the basis of what the State of New Jersey Department of Institutions and Agencies has already decided it will pay, thus therefore allowing the physician a free choice of patients as well as the patients a free choice of physicians.

First "resolved" amended by the Reference Committee and the House to read:

RESOLVED, that The Medical Society of New Jersey petition the Medicaid Commission to make available to a practicing physician, upon request, his own fee profiles and the allowances to him assigned by the Carrier, together with an explanation of the mechanism by which the figures are arrived at; and be it further

Adopted as amended by the Reference Committee and the House (page 436)

Terminology For Medicare And Insurance Reports

Current Procedural Terminology will be a highly practical aid to you in settling claims for compensation through insurance companies or Medicare-Medicaid. It is a uniform system of terminology and coding which provides you with a swift and simple way to describe accurately any diagnostic or therapeutic procedures you have undertaken. It includes alphabetical and numerical listing of procedures and the use of special headings and sections. This new edition has introduced a key-work-in-context index for the listing of surgical terms by organ or part; a special listing of procedures related to internal medicine; and the addition of many more procedures than in the first edition. You can get a copy for $2 . . . and what else can you buy for $2 these days? Send your check to the AMA at 535 North Dearborn Street, Chicago 60610 and ask for *Current Procedural Terminology*, as described in *The Journal* of The Medical Society of New Jersey.

#20

Criteria Used by Fiscal Intermediaries in Reviewing Physicians' Services

From William M. Chase, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, the fiscal intermediaries have undertaken to review the services of physicians for evidence of overutilization, abuse, and fraud; and

Whereas, it appears that such scrutiny is not done by a peer review panel; and

Whereas, the notification of the results of this review is being directed to the attention of patients with the inference that the services rendered were not good medical practice or suggesting that these services are useless forms of treatment; now therefore be it

RESOLVED, that The Medical Society of New Jersey take a stand against such practice, so as to protect the judgment and character of physicians who may be exposed to legal actions as a result of such letters; and be it further

RESOLVED, that The Medical Society of New Jersey request the carriers to call to the attention of every physician in the State any procedure or modality which has been designated by the Federal Government as unacceptable for Medicare Reimbursement.

Adopted (page 436)

#21

Interrelationship Between Medicaid and the Rehabilitation Commission

From William M. Chase, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, there are guidelines established for the interrelationship between the Public Assistance programs and the New Jersey Rehabilitation Commission; and

Whereas, with the implementation of the New Jersey Medical Assistance and Health Services Program these services have been expanded and liberalized; and

Whereas, the fiscal structure of the Medicaid Program is broader than that of the Rehabilitation Commission; and

Whereas, there is at present no provision for an interplay of financial responsibility between these two agencies; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey appoint a committee to study the past guidelines and arrive at such revisions so as to up-date the relationship between Medicaid and the New Jersey State Rehabilitation Commission, thereby effecting uniformity in these guidelines throughout the State.

Adopted (page 436)

#22

Payment for Physicians Services in Outpatient Department for Recipients of Title XIX

From the Camden County Medical Society

(Reference Committee "E")

Whereas, "out patient services" is included in the eligible services under Title XIX (Medicaid Program); and

Whereas, the regulations of the program dictate that hospitals alone can file a claim for this service, the physician not being allowed to file a claim; and

Whereas, the only way physicians may be paid for their services is that they have a contract arrangement with the hospital for the payment of the professional component, such as full time men; and

Whereas, this regulation leads to control of hospital appointment and discipline of physicians unwilling to serve without proper compensation; and

Whereas, this promotes a desire for hospitals to attempt to carry out the corporate practice of medicine; and

Whereas, the Congress and the State Board of Control are desirous that recipients have their own private physicians; and

Whereas, Title XVIII (Medicare) distinguishes between the service and the professional components of a fee while Title XIX does not have this requirement; now therefore be it

RESOLVED, that the House of Delegates declares its displeasure and deep concern with this regulation; and be it further

RESOLVED, that this House directs the Board of Trustees to use its good offices to correct this regulation by seeking a change allowing the physician serving in the out patient department to file a claim for the professional component fee or require hospitals to enter into contracts with physicians who serve in their out patient departments.

Foregoing "resolved" amended by the Reference Committee and the House to read:

RESOLVED, that this House directs the Board of Trustees a) to use its good offices to modify this regulation by seeking a change allowing the physician serving in the out-patient department to file a claim for the professional component partion of the out-patient fee or b) to urge hospitals to enter into contracts with physicians who serve in their out-patient departments, as may be authorized by law.

Adopted as amended by the Reference Committee and the House (page 436)

Timely Tips On German Measles

The latest addition to the American Medical Association's "Timely Tips on Health and Safety" is called "Waging War on German Measles." It is one of the series of flyers and envelope stuffers that have been found to be effective and inexpensive in carrying topical health messages to the public.

Forty-five different "Tip" topics are now available to you. They are used extensively in pamphlet reading racks, at health fairs, in physicians' reception rooms and even as statement enclosures. Three of the flyers are also printed in Spanish. The copy recommends methods to control health care expenses, how to be a good patient, and how to use drugs sensibly.

Each "Tip" subject may be ordered from the AMA at 20¢ per 100. Orders from medical societies are accorded the customary 50 per cent discount.

#23

Glass Door Hazards

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, there is a large and apparently increasing number of injuries caused by the breakage of glass in doors, especially storm and sliding patio doors; and

Whereas, the school and child health committee of the Bergen County Medical Society has considered at length the matter of such injuries; now therefore be it

RESOLVED, that The Medical Society of New Jersey introduce appropriate legislation to insure that only safety materials (glass or plastic) be used in all new glass doors and that the public be urged to replace existing unsafe glass in doors with safety materials.

Foregoing "resolved" amended by the Reference Committee to read:

RESOLVED, that The Medical Society of New Jersey request the Governor to introduce appropriate legislation to insure that only safety materials (glass or plastic) be used in all new glass doors and that the public be urged to replace existing unsafe glass in doors with safety materials.

Adopted as amended by the Reference Committee **(page 437)**

#24

Stronger Program to Protect and Enhance Our Environmental Resources

From the Bergen County Medical Society

(Reference Committee "G")

Whereas, the medical profession seeks to conserve and enhance human *resources;* and

Whereas, our environment is essential to the actual maintenance of life and well being; now therefore be it

RESOLVED, that The Medical Society of New Jersey enter upon a stronger program to protect and enhance our environmental resources, our very lifelines, namely air, water and land, by a more active leadership in the following:

1. Recognition of the pressing need for a balanced ecology

2. Participation in improving the hygiene of our environment by demanding:

   a) the maintenance of the Oxygen Cycle and Food Chain through insistence on preservation of open land and cessation of stream and ocean pollution

   b) the recycling of all wastes and cessation of air pollution

c) a change in our modes of transportation, through use of clean efficient mass transit to relieve our highway congestion and slaughter

d) stringent and immediate control of pesticides, additives, radioactive material, detergents, unneeded fertilizers, defoliants

e) anticipation of hazards, and action to demand proof of harmlessness of products prior to exposure of the populace

3. Greater aid to population control

4. Collection of clinical data from private practice and through research in our medical schools on environmental effects and human health, such data to be freely offered and submitted at the appropriate places (as public hearings) to inform and assist decision makers to develop legislation and programs to protect human and environmental resources

5. Support of and cooperation with the newly formed Environmental Protection Council of the State of New Jersey

6. Communication of our understanding of environmental problems and their solutions to the public we serve

7. That each member personally commit himself to make those modifications in his daily life (as an example to the community and as a responsible citizen) to bring about the changes so sorely needed to preserve our earthly habitat.

Adapted (poge 441)

#25

Establishment of New Conjoint State and County Public Relations Program

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, an educated public has the right to be continually informed in an impartial and honest manner of Medicine's points of view; and

Whereas, to accomplish this in an efficient and effective manner requires an on-going and full-time effort on the part of a well planned professional public relations program conjointly involving the twenty-one county medical societies and The Medical Society of New Jersey; now therefore be it

RESOLVED, that such a continuous, centralized, and active public relations program be established by The Medical Society of New Jersey, and that the officers and Trustees of The Medical Society of New Jersey be directed to fund and activate such a program immediately.

Foregoing resalutian amended by the Reference Committee by the fallawing additians to the "resalved":

;and be it further

RESOLVED, that an assessment af $20 per member be levied in 1971 to pay specifically for a professianal public relatians firm ta implement a pasitive, aggressive, coordinated, angoing public relations program to educate the public and the physician in canjunctian with state and county public relations committees. This public relations ogency is to make regular statewide ond locol news releoses, promote exhibits, schaal pragrams, organizatianal contacts, PTA group educatian, ond be available far the rebuttal of unfovorable publicity, and be it further

RESOLVED, that The Medical Saciety af New Jersey's Baord of Trustees and AMA Delegates recammend a similar pragram for all 50 states.

Nat adopted (page 439)

#26

Health Education as a Curricular Component

From Carye-Belle Henle, M.D., Delegate from Essex County

(Reference Committee "G")

Whereas, it is generally agreed that the teaching of health education should be an integral part of our school curriculum; and

Whereas, present efforts do not appear entirely successful in reducing the incidence of venereal disease, nutritional deficiencies, and out of wedlock pregnancy; and

Whereas, the medical aspects of this problem cannot be entirely separated from the social and educational aspects of subject; now therefore be it

RESOLVED, that The Medical Society of New Jersey offer cooperation, through a joint committee, to the New Jersey State Department of Education in formulating a coordinated up-to-date program of instruction that may serve as a guide to the local boards of education.

Adopted (page 441)

#27

Alcoholism Detection Clinics

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, alcoholism is a detectable and controllable disease recognized among such major health threats as cancer and heart disease; and

Whereas, the pioneer, Bergen County Medical Society-sponsored project, "Alcoholism Detection Clinic" at Bergen Pines County Hospital, January 1970, was attested to have been a success by: the President of the National Council on Alcoholism, The American Medical Association Council on Alcoholism, W. J. Harris, Chief of the Alcoholism Control Program of the New Jersey State Department of Health; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend the concept of an Alcoholism Detection Clinic and its methadology to all component societies, urging them to carry out similar projects in conjunction with Alcoholism Information Month, January, 1971.

Not adopted, referred to Committee on Alcoholism for study and recommendation (page 439)

#28

Extensively Liberalizing the Laws on Abortion

From John Winslow, M.D., Delegate, Essex County

(Reference Committee "A")

Whereas, it has long been known that New Jersey has antiquated laws regarding abortion that cry out for revision, and the State Legislature has taken cognizance of that fact by the establishment of the Crane Commission, which group made a thorough study of the problems relating to abortion in this state and produced a very commendable report which suggested some liberalization of the laws but under proscribed limits which are so strict that they would have little effect in stopping the majority of clandestine abortions but would just help in certain cases where the health and sanity of the mother might be affected or where a foetus with birth defects might ensue; and

Whereas, the State of New York, in a recent development of major national consequence, has just passed laws concerning abortion which make the matter of the performance of abortion (up to the 6th month of pregnancy) solely a private one between the pregnant woman and a physician; and

Whereas, the new abortion laws in New York State have the effect of almost negating any laws which are much less liberal in New Jersey and other neighboring states; and

Whereas, the general trend of sociological thinking in this country is towards allowing abortions to be done much more freely, depending only on the personal ethical feelings of the pregnant woman and the physician who would perform the abortion; and

Whereas, abortions are and will continue to be performed in a clandestine fashion unless they are allowed freely in regular medical channels; there are serious medical risks in much of the illicit abortion methods; and it would thus be logical that a real liberalization towards the careful medical legal performance of abortions with no real restrictions would be a very positive health measure; and

Whereas, New York State and more particularly New York City are ill prepared for a tremendous inflow of women seeking abortions starting this July 1 when the new "free" laws go into effect, and it is not right that New Jersey should burden its neighboring state with a large load of abortions, but rather New Jersey should share in the enlightenment New York has brought and should help to spread good liberalized abortion laws across the land; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as strongly urging the Legislature of the State of New Jersey to speedily draft and pass abortion laws similar to those recently passed by New York State, with content to include these features:

1. There should be no restrictions on the performance of abortion except those of good safe medical practice, up to the 6th month of pregnancy.

2. The only requirement for the performance of an abortion be that the pregnant woman requests it, not wanting the pregnancy to continue for her own private reasons, whatever they might be.

3. No physician shall be required to perform an abortion or shall any institution be required to allow them to be done within its doors. Such physician and institution shall, however, in the case of a pregnant woman who has a medical indication according to a large number of authorities for the per-

formance of an abortion, e.g., danger to the health or normal life and development of the mother or the foetus, be required to inform the said pregnant woman of the existence of the condition or conditions which are often considered indications for the performance of therapeutic abortion and inform her also that there are other physicians and institutions available if she desires to consider abortion, giving her help in contacting such other physicians and institutions.

4. A pregnant woman under age 21 but age 16 and over shall not be required to obtain parental or guardian consent for having an abortion performed (thus, keeping such individuals out of clandestine hands). Such individuals could give their own consent with no right of later retraction nor suit because an abortion had been performed.

5. Pregnant girls under age 16 should have parental or guardian consent if it is readily available for the performance of an abortion but, otherwise, a written concurring opinion by another physician would be considered adequate.

6. Studies should be made of the feasibility of having abortions performed in the outpatient department of hospitals or in medical offices with proper safeguards, both methods bringing great financial savings.

7. No physician nor institution could be declared liable for having performed an abortion provided permission had been obtained from the pregnant woman and the procedure had been done according to the usually accepted standards of good medical care.

Recommendation of Reference Committee not to adopt above resolution was rejected.

Resolution #28 was amended by the House by rewording the "resolved" to read:

RESOLVED, that The Medical Society of New Jersey go on record as strongly urging the Legislature of the State of New Jersey to either repeal all statutes in the State of New Jersey regarding abortions or speedily draft revised and liberalized laws which would include these features:

1. There should be no restrictions on the performance of abortion except those of good, safe medical practice, up to the 5th month of pregnancy.

2. The only requirement for the performance of an abortion be that the pregnant person requests it.

3. No physicians nor institutions shall be required to perform an abortion against their wishes.

4. All abortions shall be performed in recognized hospitals by fully licensed physicians.

The House did not adopt the amended version of Resolution #28 (page 429)

#29
In Support of A-1059

From the Board of Trustees

(Reference Committee "E")

Whereas, The Medical Society of New Jersey has long stressed the fact that New Jersey needs more physicaans equipped to deliver medical care to the people of the State; and

Whereas, in consequence, the Society had frequently recorded itself as favoring the establishment of two full-course medical schools in North Jersey and one in South Jersey; and

Whereas, to that end it has further recommended that the emphasis on New Jersey schools of medicine be on producing family practitioners rather than specialists or research scientists; and

Whereas, the Governor of New Jersey in his special message to the Legislature on "Education For Better Medical Care" has articulated

a program in basic agreement with these concepts; and

Whereas, in Assembly Bill 1059, the Governor has caused to be introduced legislation which would move toward accomplishing these ends more efficiently and economically; now therefore be it

RESOLVED, that The Medical Society of New Jersey endorses the message on "Education For Better Medical Care" and records its approval of Assembly Bill 1059.

Substitute Resolution for Resolutions #17, 29, 32

Whereas, The Medical Society of New Jersey has long stressed the fact that New Jersey needs more physicians equipped to deliver medical care to the people of the State; and

Whereas, in consequence, the Society has frequently recorded itself as favoring the establishment of two full medical school programs in North Jersey and one in South Jersey; and

Whereas, to that end it has further recommended that the New Jersey schools of medicine produce practicing physicians, with emphasis on general practice; and

Whereas, the Governor of New Jersey in his special message to the Legislature on "Education For Better Medical Care" has articulated a program including a coordinated plan for supervising medical education in our State; and

Whereas, in Assembly Bill 1059, the Governor has caused to be introduced legislation which would move toward accomplishing these ends more efficiently and economically; now therefore be it

RESOLVED, that The Medical Society of New Jersey endorses the message on "Education For Better Medical Care" and records its approval of Assembly Bill 1059; and be it further

RESOLVED, that The Medical Society of New Jersey, assembled in its 1970 Annual Meeting, through its House of Delegates, recommends to the Legislature and Governor, the following plan:

1. Maintain and expand the existing full medical programs and facilities at Newark.

2. Maintain the present college of medicine facility at New Brunswick, but enlarge its size to accommodate 100 students per class and expand it to a complete M.D. program as soon as possible.

3. Establish a unified Board of Trustees to serve the two existing medical schools and the third such school contemplated for Southern Jersey. It is urged that the Board include representatives of the geographic areas in which the schools are located.

4. Consider the possibility of operating each medical school on an eleven month instead of the present nine month schedule. In four years this will effect a saving of eight academic months and may make possible the shortening of the curriculum to three calendar years.

Substitute Resolution for Resolutions #17, #29, and #32 adopted as amended by the House (page 435)

#30
Drug Abuse Registry

From the Passaic County Medical Society

(Reference Committee "E")

Whereas, narcotic addiction and drug abuse constitute a major health and social problem, afflicting a significant proportion of the public; and

Whereas, much needs to be done by private and public agencies to accomplish effective prevention, education, and control; and

Whereas, there is an urgent need to educate the general public to the realization that drug addiction is an illness rather than a crime; now therefore be it

RESOLVED, that The Medical Society of New Jersey urges that legislation be enacted to establish a confidential registry of narcotic addicts and drug abusers; and be it further

RESOLVED, that narcotic addiction be made reportable as an illness rather than as an offense.

Adopted (page 437)

#31

Internships

From Daniel B. Roth, M.D., Delegate, Bergen County

(Reference Committee "E")

Whereas, the internship year has always been regarded as a basic cornerstone of the post graduate education of the recent medical graduate; and

Whereas, many of the internships are in community hospitals where a large pool of patients exist for the training of the young physician; and

Whereas, the Council on Medical Education of the American Medical Association has recommended to the Board of Trustees that the House of Delegates be advised in June that a cutoff date be set up five years hence whereby a hospital having only an internship and no residency program would no longer be approved for the training of interns; and

Whereas, this move would deprive many community hospitals of their house staffs and many young physicians of an opportunity to learn the practice of medicine as it exists in the community; now therefore be it

RESOLVED, that The Medical Society of New Jersey record itself as being in favor of continuing internships in hospitals in the communities, even though no residency programs are offered; and be it further

RESOLVED, that New Jersey's AMA Delegates be directed to register disapproval of the recommendation of the Council on Medical Education and that the Council be instructed to do all in its power to improve and enlarge the internship programs in the community hospitals.

Adopted (page 437)

#32

Medical Education in New Jersey

Henry A. Brodkin, M.D., Delegate, Essex County

(Reference Committee "E")

Whereas, New Jersey's young men and women have had to leave the state for medical education; and

Whereas, we already have a four-year and a two-year medical school in our state; and

Whereas, the cost of the construction of a teaching hospital in New Brunswick would be seriously burdensome to the taxpayers; and

Whereas, there is, now, no coordinated plan for supervising medical education, in our state; and

Whereas, a spirit of rivalry rather than cooperation already exists between our two medical schools; and

Whereas, there is, today, desperate need for facilities for training more medical practi-

tioners for New Jersey; and
Whereas, this goal should be, and can be reached with minimum disturbance of the existing establishments and at prudent cost; now therefore be it

RESOLVED, that The Medical Society of New Jersey, assembled in its 1970 Annual Meeting, through its House of Delegates, recommends to the Legislature and Governor, the following plan:

1. Maintain the present College of Medicine at Rutgers, but enlarge its size to accommodate 100 students per class. For the time being retain it as a two year college where laboratory and lecture facilities would be the prime need.

2. Recognize that some clinical work and exposure to patients is required in the first two years, but that this may be minimal; and therefore, utilize existing hospital facilities in and around New Brunswick for this limited purpose. This will obviate the need for a huge teaching hospital and all its expense in terms of cost and operation.

3. Maintain the 115 student classes at the New Jersey College of Medicine and Dentistry but enlarge the 3rd and 4th year facilities so that they can absorb the 100 students completing the 2nd year at the New Brunswick institution. Teaching here will be largely clincial and many large hospitals in the Bergen, Essex, Hudson, Passaic and Union areas may be used for this purpose by dividing the student body into small sections.

4. Establish a unified Board of Control for the two medical schools under the State University; and if later a third medical school is built in Southern Jersey let this also be under the aegis of the same board but with the addition of representatives of that area. This unified merger for the administration of the medical schools will provide an integrated coordinated Board of Trustees, eliminating competition for funds and unnecessary rivalry.

5. Consideration should be given to the possibility of operating each medical school on an eleven month instead of the present nine month schedule. In four years this will effect a saving of eight academic months and may make possible the shortening of the curriculum to three calendar years.

Substitute Resolution for Resolutions #17, 29, 32

Whereas, The Medical Society of New Jersey has long stressed the fact that New Jersey needs more physicions equipped to deliver medical core to the people of the Stote; and

Whereas, in consequence, the Society has frequently recorded itself as favoring the establishment of two full medical school programs in North Jersey and one in South Jersey; and

Whereas, to that end it has further recommended that the New Jersey schools of medicine produce practicing physicians, with emphasis on generol practice; ond

Whereos, the Governor of New Jersey in his special message to the Legislature on "Educotion For Better Medicol Care" has articulated o program including o coordinated plan for supervising medical education in our State; and

Whereos, in Assembly Bill 1059, the Governor has caused to be introduced legislation which would move toward accomplishing these ends more efficiently and economically; now therefore be it

RESOLVED, that The Medical Society of New Jersey endorses the message on "Educotion For Better Medical Care" and records its opproval of Assembly Bill 1059; and be it further

RESOLVED, that The Medical Society of New Jersey. assembled in its 1970 Annual Meeting, through its House of Delegotes, recommends to the Legislature and Governor, the following plan:

1. Maintain and expand the existing full medical progroms and facilities at Newark.

2. Maintain the present college of medicine facility at New Brunswick, but enlorge its size to accommodate 100 students per class and expond it to a complete M.D. program as soon as possible.

3. Establish a unified Board of Trustees to serve the two existing medical schools and the third such school contemplated for Southern Jersey. It is urged that the Board include representatives of the geographic areas in which the schools are located.

4. Consider the possibility of operating each medical school on an eleven month instead of the present nine month schedule. In four years this will effect a saving of eight academic months and may make possible the shortening of the curriculum to three calendar years.

Substitute Resolution for Resolutions #17, #29 and #32 adopted as amended by the House (page 435)

#33

Physicians' Exclusive Right to Render Medical Judgments

From the Monmouth County Medical Society

(Reference Committee "E")

Whereas, the practice of medicine is being increasingly burdened by governmental regulations; and

Whereas, the health and welfare of the patient are the primary responsibility of his personal physician; and

Whereas, there are occurring increasing instances of decisions rendered by paramedical and lay people, which should be the prerogative only of the treating physician; now therefore be it

RESOLVED, that The Medical Society of New Jersey utilize its full resources to ensure that medical decisions remain the domain of the physician only, and that no such decisions may be effected by lay people; furthermore be it

RESOLVED, that The Medical Society of New Jersey utilize its full resources to ensure that all policy decisions, federal, state and local, be reached only with full consultation with qualified treating physicians.

Adopted (page 437)

#34

Oral Contraceptives

From the Morris County Medical Society

(Reference Committee "G")

Whereas, since the meeting of the Committee on Maternal and Infant Welfare the federal government has made mandatory adequate package warnings to the users of birth control pills; and

Whereas, there is no test that can be employed at any time scientifically and accurately to predict thrombophlebitis; and

Whereas, the necessity and desirability of all women on the birth control pills to be seen at six month intervals has not been demonstrated scientifically; and

Whereas, such requirements as recommended would produce a greatly increased work load upon physicians preventing them from seeing others with disease and those needing physician services; now therefore be it

RESOLVED, that the recommendations contained in paragraphs 2, 3, and 4 under the heading of Oral Contraceptives in the Maternal and Infant Welfare Committee report not be approved because the recommendations are unnecessary, unscientific, and undesirable.

Foregoing "resolved" amended by the Reference Committee to read:

RESOLVED, that the recommendation contained in paragraph 2 under the heading of "Oral Contraceptives" in the Maternal and Infant Welfare Committee report not be approved because the recommendation is unnecessary and undesirable.

Adopted as amended by the Reference Committee (page 441)

#35

Blue Cross-Blue Shield Coverage for Psychiatric Services

From the Morris County Medical Society

(Reference Committee "C")

Whereas, resolution #19 (1969 House of Delegates) was not implemented; and

Whereas, adequate insurance coverage for patients with psychiatric diagnoses is still not provided by MSP or HSP; and

Whereas, substantial premium rate increases were provided for MSP-HSP; now therefore be it

RESOLVED, that The Medical Society of New Jersey continue the pursuit of negotiations with MSP-HSP in order to provide adequate insurance coverage for patients with psychiatric diagnoses who are cared for by a physician.

Not adopted. It was noted that the content of the above resolution is adequately dealt with in Section 1-b of the report of Reference Committee "C" (page 431)

#36

Support of AMA Rebuttal to CBS Telecast

From Albert F. Moriconi, M.D., Delegate Mercer County

(Reference Committee "F")

Whereas, the Columbia Broadcasting System recently placed before its television public two hours of extremely biased and demeaning views of doctors of medicine and of the medical profession; and

Whereas, it placed blame unfairly upon the medical profession for instances of poor medicine practiced in certain small isolated areas of the United States; and

Whereas, it indirectly supported governmental interference with the practice of medicine; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as supporting the action of the American Medical Association and the National Medical Association in answering the telecast presented by the Columbia Broadcasting Systems; and be it further

RESOLVED, that this Society through its Council on Public Relations make available to the American Medical Association and the National Medical Association whatever resources are available to aid in this rebuttal.

Adopted (page 439)

REFERENCE COMMITTEES

Reference Committee "A"

Joseph M. Gannon, M.D., Chairman

Reference Committee "A" met on Sunday, 17 May 1970, with all members present: Doctors Karl T. Franzoni, Robert S. Gamon, Jr., William C. Rainer, Leopold E. Thron, and the chairman. Approximately 20 delegates and members were present to discuss the various items under consideration.

1. **President** (page 305)

The Committee **recommends** that the report be approved.

Adopted

2. **Board of Trustees**—Items (page 315)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved.

The Committee **recommends** that the report be approved.

Adopted

a. **Joint Conference with Presidents of Component Societies** (page 316)

The Committee **recommends** that the report be approved.

Adopted

b. **Professional Liability Panel** (page 317)

The Committee **recommends** that the report be approved.

Adopted

c. **Special Committee to Review the Report of the AMA Committee on Planning and Development** (Supplemental, page 320)

The Committee **recommends** that the report be approved.

Adopted

3. **Secretary** (page 307)

The Committee **recommends** that the report be approved.

Adopted

4. **Judicial Council** (page 322)

The Committee **recommends** that the report be approved.

Adopted

5. **Executive Director** (page 326)

The Committee **recommends** approval of the report.

Adopted

6. **Credentials** (page 331)

The Committee **recommends** that the report be approved.

Adopted

Reference Committee "A" wishes to express appreciation to the officers and committees for the effort expended in the preparation of the foregoing reports.

7. **Admission of Osteopaths to MSNJ Membership** (pag 378)

The Committee **recommends** that the report be approved. In making this recommendation, Reference Committee "A" does not wish its recommendation to be construed as a cate-

gorical objection to the inclusion of fully licensed doctors of osteopathy into The Medical Society of New Jersey; time and more felicitous circumstances may make such membership desirable.

Adopted

8. **Resolutions:**

a. **Support of All Programs of Nursing Education**—Resolution #1 (page 401)

The Committee **recommends** adoption of this resolution.

Adopted

b. **Assimilation of Osteopaths**—Resolution #2 (page 401)

In view of your Committee's recommendation that the report of the Committee on Admission of Osteopaths be approved, your Committee **recommends** that this resolution be not adopted.

Adopted

c. **Establishment of Office of Professional Medicare Liaison Within Prudential Insurance Company**—Resolution #3 (page 402)

Inasmuch as MSNJ has established a Joint Medicare Claims Inquiry Committee, and inasmuch as a member of our Society—Dr. James Brennan—is now Medical Director for Government Health Insurance Programs with the Prudential Insurance Company, the Committee **recommends** that this resolution be not adopted.

Not Adopted

Resolution #3 was adopted by action of the House.

d. **Extensively Liberalizing the Laws on Abortion**—Resolution #28 (page 421)

This resolution contains an abundance of specific proposals that essentially are incompatible with the Society's official policy on abortion. The Committee therefore **recommends** that Resolution #28 be not adopted.

The recommendation of the Reference Committee not to adopt was rejected.

Resolution #28 was amended by the House by changing the "Resolved" to read as follows:

RESOLVED, that The Medical Society of New Jersey go on record as strongly urging the Legislature of the State of New Jersey to either repeal all statutes of the State of New Jersey regarding abortion or speedily draft revised and liberalized laws, which would include these features:

1. There should be no restrictions on the performance of abortion except those of good safe medical practice, up to the 5th month of pregnancy.

2. The only requirement for the performance of an abortion be that the pregnant person requests it.

3. No physicians nor institutions shall be required to perform an abortion against their wishes.

4. All abortions shall be performed in recognized hospitals by fully licensed physicians.

The House did not adopt the amended version of Resolution #28.

Reference Committee "B"

Henry O. vonDeilen, M.D., Chairman

Reference Committee "B" met on Sunday, 17 May 1970, with all members present: Doctors Charles Cunningham, Carl A. Restivo, John S. Van Mater, Robert A. Weinstein, and the chairman. Approximately 16 delegates and members were present to discuss the various items under consideration.

1. **Treasurer** (page 308)

The Committee commends the Treasurer on the excellence of his report and **recommends** that it be approved.

Adopted

1. **Finance and Budget** (page 332)

Many inquiries and much discussion developed on the new budget because of the increase of $33,000. However, this was explained to the Committee's satisfaction.

The Committee **recommends** that the report be approved.

Adopted

The Committee further **recommends** that the budget for 1970-71 be adopted in the total sum of $407,067.00, and that the 1971 assessment be adopted at $55 per capita.

Adopted

3. **Medical Student Loan Fund** (page 340)

The Committee **recommends** that the report be approved and further **recommends** that because of the increasing demand for loans that the present percentage of the net which is available for loans be increased from 20 to 25 per cent.

Adopted

4. **Publication** (page 343)

The Committee **recommends** approval of the report as submitted and commends the Editor on a good job.

Adopted

5. **Project Hope/Vietnam** (page 383)

The Committee **recommends** that the report be approved.

Adopted

6. **Resolutions:**

a. **Statewide Automated Bookkeeping, Accounting, and Billing System—Resolution #4,** (page 403)

Reference Committee "B" amended the "RESOLVED" portion of Resolution #4 to read: (amendment indicated by italics)

RESOLVED, that The Medical Society of New Jersey investigate *and report at the 1971 Annual Meeting* on an automated modern system of bookkeeping, accounting, and billing and make the advantages of such system available to all component medical societies on a fair basis of cost.

The Committee **recommends** that the report be approved.

The foregoing "Resolved" was amended by the House by deleting "and report at the 1971 Annual Meeting an," by changing the period to a comma, and by adding "if found feasible; and that the Board of Trustees be empowered to put such automated system into effect." The amended "Resolved" reads:

RESOLVED, that The Medical Society of New Jersey investigate an automated modern system of bookkeeping, accounting, and billing and make the advantages of such system available to all component medical societies on a fair basis of cost, if found feasible; and that the Board of Trustees be empowered to put such automated system into effect.

Adopted as amended by the House.

b. **Physicians' Welfare Fund—Resolution #16** (page 413)

The Committee **recommends** that Resolution #16 be disapproved. However, the Committee agrees with the intent of the resolution and suggests that the Board of Trustees appoint a Committee to define the terms of the administration of such a fund and that it be financed annually by a dollar per capita taken from surplus.

Adopted

Psoriasis: A Status Report

An illustrated, four-color reprint from the June 1969 *GP* on "Psoriasis: A Status Report" is now offered to physicians upon request by the AMA Committee on Cutaneous Health and Cosmetics. Prepared by Richard M. Caplan, M.D., the report covers etiology, pathogenesis, lesions, treatment, and use of corticosteroid hormones.

Reference Committee "C"

John J. McGuire, M.D., Chairman

Reference Committee "C" met on Sunday, 17 May 1970, with all members present: Doctors Harry R. Brindle, Edward Foord, Vincent H. Gillson, Joseph A. Lepree, and the chairman. Approximately 28 delegates and members, and 7 invited guests were present to discuss the various items under consideration.

1. **Board of Trustees**—Items

a. **MSP Board of Trustees**—Nominations (page 316)

The Committee **recommends** approval of this report.

Adopted

b. **MSP-HSP Coverage for Psychiatric Patients** (page 317)

At the present time there is a 21-day in-hospital patient care coverage with Blue Cross and Blue Shield. Experience-rated groups such as General Motors and other large groups do have out-patient coverage in their contract.

The Committee **recommends** that a study be undertaken by the New Jersey Neuropsychiatric Association and MSP regarding out-patient coverage for small groups and individual subscribers.

Adopted

The Committee further **recommends** that further action concerning this coverage be deferred pending report of the above recommended study.

Adopted

c. **Referrals to the Conference Committee on Inter-Relations with the Judiciary and Bar** (page 317)

The Committee **recommends** approval of this report.

Adopted

2. **Medical-Surgical Plan of New Jersey** (annual statement and report, page 387

The Committee **recommends** approval of this item.

Adopted

3. **Medical Defense and Insurance** (page 334)

The Committee notes that the problem of importing adequate information to the membership of The Medical Society of New Jersey is demandingly important. It therefore recommends to the Standing Committee that it take steps to evolve a satisfactory mechanism for the dissemination of information regarding the causes of individual malpractice suits.

The Committee **recommends** approval of this report.

Adopted

4. **Retirement Plan for Physicians** (page 384 and supplemental, page 384)

The Committee **recommends** approval of this report.

Adopted

5. **Resolution:**

Blue Cross-Blue Shield Coverage for Psychiatric Services—Resolution #35 (page 427)

The Committee noted that Resolution #35 is adequately dealt with in Section 1-b of this report.

The Committee therefore **recommends** that this resolution be not adopted.

Adopted

Reference Committee "D"

Donald T. Akey, M.D., Chairman

Reference Committee "D" met on Sunday, 17 May 1970, with all members present: Doctors Sherman Garrison, John P. Kengeter, Gabor Somjen, Nelson Walker, and the chairman. Approximately 16 delegates and members were present to discuss the various items under consideration.

1. **Medical Education** (page 340)

The Reference Committee would like to congratulate the Committee on Medical Education for their hard work in the past year. Also, the Reference Committee would like to encourage the Committee on Medical Education to establish a program providing more continuity and coordination among facets of continuing education. Emphasis was placed on a method to record and establish credits for member participation.

The Committee **recommends** approval of this report.

Adopted

2. **Emergency Medical Care** (page 382)

The Committee discussed the recommendations previously approved by the Board of Trustees as contained in the report of the Committee on Emergency Medical Care. The Reference Committee felt that a follow-up of proper signs within the local communities—directing motorists to the nearest hospital—is highly desirable.

The Committee **recommends** approval of this report.

Adopted

3. **Medicine and Religion** (page 383)

The Committee **recommends** approval of this report.

Adopted

4. **Traffic Safety** (page 385)

The Committee **recommends** approval of this report.

Adopted

5. **Resolutions:**

a. **Mobile Coronary Care Unit**—Resolution #5 (page 404)

The Committee **recommends** that Resolution #5 be not adopted.

Adopted

b. **Proposed National Academy of the Health Professions for Research and Policy**—Resolution #6 (page 405)

The Committee **recommends** adoption of this resolution.

Adopted

Support the Society for

Relief of Widows and Orphans

Reference Committee "E"

Frederick W. Durham, M.D., Chairman

Reference Committee "E" met on Sunday, 17 May 1970, with all members present: Doctors Paul J. Kreutz, Roy A. Morrow, Bernard D. Pinck, Robert G. Salasin, and the chairman. Approximately 100 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees**—Items

a. **Committee on Extension to Interns and Residents of Power to Sign Certain Legal Documents** (page 318)

The Committee **recommends** approval of this report, however, it feels that the privilege involved should be extended to all New Jersey hospitals. It therefore **recommends** that The Medical Society of New Jersey request the State Board of Medical Examiners to obtain a formal opinion from the Attorney General relevant to this matter.

Adopted

b. **Medicaid Peer Review Committee** (page 321)

The Committee **recommends** approval of this report.

Adopted

c. **Medical Advisory Committee to the Medicaid Program** (page 319)

The Committee **recommends** approval of this report.

Adopted

2. **Legislation** (page 348 and supplemental, page 357)

The Committee is appreciative of the monumental efforts of Doctor Jesse McCall and his fellow members of the Council on Legislation during the past year. Some 2,000 pieces of legislation were reviewed. The Legislative Analyst, the Council, the keymen, and the staff were commended by speakers from the floor.

The Committee **recommends** the approval of this report.

The House amended the foregoing report by changing the official position of MSNJ on A-762 from DISAPPROVED to APPROVED. (page 359)

Adopted as amended by the House.

3. **Medical Services** (page 360)

Utilization Review Committees (page 360)

The Committee approves this portion of the report with the **recommendation** to the Council that in addition to these guidelines, the function and scope of utilization review committees and their relationship to all third party payors be comprehensively defined.

Adopted

Relative Value Index (page 361)

The Committee supports the recommendation of the Council on Medical Services as set forth in subsection a) page 361.

It, therefore, **recommends** approval of this report.

Adopted

4. **Occupational Health, Workmen's Compensation, and Rehabilitation**—(page 362)

The Committee **recommends** approval of this report.

Adopted

5. Resolutions:

a. **Immunity for Physicians Volunteering Their Services In State Medical Programs**—Resolution #7 (page 405)

With the approval of the sponsor of Resolution #7, the Committee **recommends** adoption of this resolution with the following amendments to the RESOLVED: (indicated by italics)

RESOLVED, that The Medical Society of New Jersey *request the Governor and the State Department of Health to* seek enactment of State legislation which would provide *licensed physicians and their professional societies* with immunity from litigation which may arise from the rendering of professional services voluntarily in any diagnostic, preventive, or therapeutic health program recommended, endorsed, or requested by the New Jersey State Department of Health.

Adopted

b. **Compensation of Physicians Under Medicare and Medicaid**—Resolution #8 (page 406)

The Committee **recommends** that this resolution not be approved as in contravention of official policy established by the House of Delegates and repeatedly affirmed.

Adopted

c. **Legislative Approach to Malpractice**—Resolution #9 (page 407)

The Committee **recommends** that this resolution not be approved, but referred to the Joint Committee of the Council on Legislation and the Committee on Medical Defense and Insurance and that the elements contained therein be dealt with promptly.

By action of the House Resolution #9 was approved in principle and referred to the Council on Legislation and Committee on Medical Defense and Insurance.

d. **Opposition to the Legalization of Marihuana**—Resolution #10 (page 408)

With the approval of the sponsor of Resolution #10, the Committee **recommends** adoption of this resolution with the following amendments:

In the fourth "Whereas" delete "by our youth."

The second "RESOLVED" should read as follows: (amendment indicated by italics)

RESOLVED, that the Society assume leadership in advising the public that it is against *relaxing* laws related to the illicit sale or smuggling of the drug for sale purposes; and be it further . . .

Adopted

e. **Temporary Licensure of Certain Foreign Physicians**—Resolution #11 (page 409)

With the approval of the sponsor of Resolution #11, the Committee **recommends** adoption of the following substitute resolution:

Whereas, there is a critical shortage of physicians in New Jersey adequately to meet the needs of the community; and

Whereas, most of the hospitals of New Jersey are having difficulty in filling their internships and residencies with physicians trained in the United States; and

Whereas, many of these interns and residents are graduates of foreign medical schools who are in this country on temporary visas and intend to return to their home countries; and

Whereas, these foreign graduates, having completed their internships and residencies, are often available to serve as house physicians and surgeons in hospitals with or without an intern or residency program; and

Whereas, under the Medical Practice Act of New Jersey these qualified and well-trained physicians cannot be employed unless licensed by the State of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey vigorously seek the enactment of legislation to exempt eligible physicians (as defined hereunder) from the prohibitory provisions of the Medical Practice Act while they are in the employ of a hospital licensed by the State of New Jersey. No physician shall be granted this exemption for longer than a period of three years.

Eligible physicians shall be those physicians who have completed an internship or residency in a hospital in the United States which has been approved by the Education Council of the American Medical Association (or American Osteopathic Association).

Not Adopted—originol Resolution #11 olso not odopted

f. **Medicare Billing Forms**—Resolution #12 (page 410)

The Committee **recommends** the approval of this resolution.

Adopted

g. **Medical School Program** at Rutgers—Resolution #17 (page 413)
In Support of A-1059--Resolution #29 (page 422)
Medical Education in New Jersey—Resolution #32 (page 424)

These resolutions all bear upon medical education in New Jersey. Your Committee **recommends** that they be not adopted but that in their stead the following substitute resolution be adopted:

Whereas, The Medical Society of New Jersey has long stressed the fact that New Jersey needs more physicians equipped to deliver medical care to the people of the State; and

Whereas, in consequence, the Society has frequently recorded itself as favoring the establishment of two full medical school programs in North Jersey and one in South Jersey; and

Whereas, to that end it has further recommended that the emphasis in New Jersey schools of medicine be on producing general practitioners; and

Whereas, the Governor of New Jersey in his special message to the Legislature on "Education For Better Medical Care" has articulated a program including a coordinated plan for supervising medical education in our state; and

Whereas, in Assembly Bill 1059, the Governor has caused to be introduced legislation which would move toward accomplishing these ends more efficiently and economically; now therefore be it

RESOLVED, that The Medical Society of New Jersey endorses the message on "Education For Better Medical Care" and records its approval of Assembly Bill 1059; and be it further

RESOLVED, that the Medical Society of New Jersey, assembled in its 1970 Annual Meeting, through its House of Delegates, recommends to the Legislature and Governor, the following plan:

1. *Maintain the present college of medicine facility at New Brunswick, but enlarge its size to accommodate 100 students per class and expand it to a complete M.D. program as soon as possible.*

2. *Establish a unified Board of Trustees to serve the two existing medical schools and the third such school contemplated for Southern Jersey. It is urged that the Board include representatives of the geographic areas in which the schools are located.*

3. *Consider the possibility of operating each medical school on an eleven month instead of the present nine month schedule. In four years this will effect a saving of eight academic months and may make possible the shortening of the curriculum to three calendar years.*

Foregoing resolution amended by the House by chonging the 3rd "Whereos" to reod:

Whereos, to that end it has further recommended thot New

Jersey schools of medicine produce practicing physicians with emphasis on general practitioners: and

by inserting item #1 under the second "Resolved":

1. Maintain and expand the existing full medical program ond facilities at Newark.

by renumbering the remaining items as #2, #3, and #4.

The amended resolution reads:

Whereas, The Medical Society of New Jersey has long stressed the fact that New Jersey needs more physicians equipped to deliver medical care to the people af the State; and

Whereas, in consequence, the Society has frequently recorded itself as favoring the establishment of two full medical school programs in North Jersey and one in South Jersey; and

Whereas, to that end it has further recommended thot New Jersey schools of medicine produce practicing physicians with emphasis on general practitioners; and

Whereas, the Governor of New Jersey in his special message to the Legislature on "Education For Better Medical Care" has articulated a program including a coordinated plan for supervising medical education in our State; and

Whereas, in Assembly Bill 1059, the Governor has caused to be introduced legislotion which would move toward accomplishing these ends more efficiently and economically; now therefore be it

RESOLVED, that the Medical Society of New Jersey endorses the message on "Education For Better Medical Core" and records its approval of Assembly Bill 1059; and be it further

RESOLVED, that the Medical Society of New Jersey, assembled in its 1970 Annual Meeting through its House of Delegates, recommends to the Legislature and Governor, the following plon:

1. Maintain and expand the existing full medical program and facilities at Newark.

2. Maintain the present college of medicine facility at New Brunswick, but enlarge its size to accommodate 100 students per class ond expand it to a complete M.D. program as soon as possible.

3. Establish a unified Board of Trustees to serve the two existing medical schools and the third such school contemplated for Southern Jersey. It is urged that the Board include representatives of the geographic areas in which the schools are located.

4. Consider the possibility of operating each medical school on an eleven month instead of the present nine month schedule. In four years this will effect a saving of eight academic months and may moke possible the shortening of the curriculum to three calendar years.

Adopted as amended by the House.

h. Compensation Under Medicaid—Resolution #19 (page 415)

With the approval of the sponsor of Resolution #19, the Committee recommends adoption of this resolution with the following amendment:

The first "RESOLVED" should read:

RESOLVED, that The Medical Society of New Jersey petition the Medicaid Commission to make available to practicing physicians upon request their own fee profiles; . . .

Foregoing "Resolved" amended by the House by adding "and the allowance assigned by the carrier and the mechanism by which that allowance is determined; . . .

The amended "Resolved" reads:

RESOLVED, that The Medical Society of New Jersey petition the Medicaid Commission to make available to a practicing physician, upon request, his own fee profiles and the allowance to him assigned by the carrier, together with an explanation of the mechanisms by which the figures are arrived at: and be it further

Adopted as amended by the Reference Committee and by the House.

i. Criteria Used By Fiscal Intermediaries In Reviewing Physicians' Services—Resolution #20 (page 416)

The Committee recommends approval of this resolution.

Adopted

j. Interrelationship Between Medicaid and the Rehabilitation Commission—Resolution #21 (page 416)

The Committee recommends approval of this resolution.

Adopted

k. Payment for Physicians' Services In Out Patient Department for Recipients of Title XIX—Resolution #22 (page 417)

With the approval of the sponsor of Resolution #22, the Committee recommends adoption of this resolution with the following amendment:

The last 'RESOLVED" should read: (amendments indicated by italics)

RESOLVED, that this House directs the Board of Trustees a) to use its good offices to *modify* this regulation by seeking a change allowing the physician serving in the outpatient department to file a claim for *his* pro-

fessional fee, or b) to *urge* hospitals to enter into contracts with physicians who serve in their out-patient departments, *as may be authorized by law.*

Foregoing "Resolved" amended by deleting "his professional fee" and inserting "the professional component portion of the out-patient fee."

The amended "Resolved" reads:

RESOLVED, that this House directs the Board of Trustees (a) to use its good offices to modify this regulation by seeking a change allowing the physician serving in the out-patient department to file a claim for the professional component portion of the out-patient fee, or (b) to urge hospitals to enter into contracts with physicians who serve in their out-patient departments, as may be authorized by law.

Adopted as amended by the Reference Committee and the House.

1. **Glass Door Hazards**—Resolution #23 (page 418)

With the approval of the sponsor of Resolution #23, the Committee **recommends** adoption of this resolution with the following amendment:

The "RESOLVED" should read as follows: (amendment indicated by italics)

RESOLVED, that The Medical Society of New Jersey *request the Governor to* introduce appropriate legislation to insure that only safety materials (glass or plastic) be used in all new glass doors and that the public be urged to replace existing unsafe glass in doors with safety materials.

Adopted

m. **Drug Abuse Registry**—Resolution #30 (page 423)

The Committee **recommends** approval of this resolution.

Adopted

n. **Internships**—Resolution #31 (page 424)

The Committee **recommends** approval of this resolution.

Adopted

o. **Physicians' Exclusive Right to Render Medical Judgments**—Resolution #33 (page 426)

The Committee **recommends** approval of this resolution.

Adopted

The Nurse And Diabetes Control

In diabetes control, the nurse plays a major role. She often has an opportunity for early recognition of the possibility and can arrange for testing. She provides nursing care of the acute diabetic. She has considerable responsibility for referral and follow-up. She can be material in that ounce of prevention that, in Dr. Krosnick's words, can "save life, limbs, and money." She can counsel on many of the social and emotional problems associated with diabetes, including problems for the family members.

Diabetics must learn something about disease self-management, and the nurse can often be the one to teach this. All this and a lot more is in an illustrated 30-page brochure by Arthur Krosnick, M.D., a member of The Medical Society of New Jersey and a coordinator of diabetes and endocrine disease programs in our State Department of Health. Dr. Krosnick is also a consultant to the National Center for Chronic Disease Control (USPHS) and is on the faculty of the University of Pennsylvania. Want a copy for your office staff? Write to Department of Health, P.O. Box 1540, Trenton, New Jersey 08625.

Reference Committee "F"

William Greifinger, M.D., Chairman

Reference Committee "F" met on Sunday, 17 May 1970, with all members present: Doctors Rudolph T. DePersia, Thomas F. Flynn, Jr., Avrohm Jacobson, Louis Kosminsky, and the chairman. Approximately 21 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees**—Items

Request to Governor to Appoint a Group to Study State Mental Health Program (page 315)

The Committee **recommends** approval of the Governor's action in making an agreement with the American Psychiatric Association for a study of the State's Mental Health Program, which is presently functioning and has been since February 1970.

Adopted

2. **Mental Health** (page 363)

The Committee **recommends** approval of the report of the Council on Mental Health and directs attention to the reports of the Special Committees, which will receive individual comment.

Adopted

3. **Alcoholism** (page 364)

In our opinion this Committee should become more active, since there are many problems in the field of alcoholism which require active attention and participation on the part of MSNJ's membership. Your Committee so **recommends.**

Adopted

The Committee **recommends** approval of this report.

Adopted

4. **Drug Abuse** (page 364 and supplemental, page 366)

The Committee **recommends** that the report and supplemental be approved, and compliments the Committee on Drug Abuse, and its chairman, in particular, for a very comprehensive and lucid report.

Adopted

5. **Emotional Disorders of Childhood and Adolescence** (page 368)

The Committee **recommends** that the report be approved.

Adopted

6. **Mental Retardation** (page 368)

With the addition of the missing word "Retardation" in paragraph 6, line three, following the word "Mental," the Committee **recommends** approval of this report.

Adopted

7. **Seizures** (page 369)

The Committee **recommends** approval of this report, and further **recommends** that an enlarged version of the pocket card outlining treatment of seizure disorders be made available to every hospital for display in the emergency rooms, bearing the legend "distributed by The Medical Society of New Jersey"—as a public relations measure.

Adopted

The Committee, having reviewed the foregoing reports of the special committees, **recommends** that The Medical Society of New Jersey and its component societies become more actively engaged in all programs concerned with Mental Health.

Adopted

8. **Public Relations** (page 376)

The Committee **recommends** approval of the report as submitted, but urges that the Council on Public Relations become more actively involved with the promulgation of news releases on the activities of the Society to the news media.

Adopted

9. **Resolutions:**

a. **Separate Department of Mental Health and Mental Retardation**—Resolution #13 (page 411)

Reference Committee "F" **recommends** adoption of Resolution #13, with the following amendment: in lieu of "with a licensed physician as Commissioner thereof" to read "*with a board certified psychiatrist as Commissioner thereof.*"

Adopted

b. **Establishment of New Conjoint State and County Public Relations Program**—Resolution #25 (page 419)

Reference Committee "F" agreed to add the following to the original "RESOLVED" portion of Resolution #25:

and be it further

RESOLVED, that an assessment of $20 per member be levied in 1971 to pay specifically for a professional public relations firm to implement a positive, aggressive, coordinated, ongoing public relations program to educate the public and the physician in conjunction with state and county public relations committees. This public relations agency is to make regular statewide and local news releases, promote exhibits, school programs, organizational contacts, PTA Group education, and be available for the rebuttal of unfavorable publicity; and be it further

RESOLVED, that The Medical Society of New Jersey's Board of Trustees and AMA Delegates recommend a similar program for all 50 states.

Reference Committee "F" **recommends**, however, that the proposed assessment be increased to an amount not to exceed $50 per member.

Not adopted

Resolution #25 not adopted

c. **Alcoholism Detection Clinics**—Resolution #27 (page 420)

The Committee **recommends** that the Resolution be not adopted but referred to the Special Committe on Alcoholism for study and recommendations.

Adopted

d. **Support of AMA Rebuttal to CBS Broadcast**—Resolution #36 (page 427)

The Committee **recommends** that Resolution #36 be adopted.

Adopted

The Chairman of Reference Committee "F" wishes to express his appreciation to the members of his Committee for their patience and enthusiastic interest in the subjects presented for their consideration.

Responsibility of the Physician in Off-job Accident Prevention

More than half of all accidents to workers, and 74 per cent of the fatal ones occur off the job. The responsibilities of the industrial physician to both his company and its employees, and also to his community, therefore, must certainly include aggressive and imaginative measures to prevent accidents that occur outside working hours.

—Kiefer, N. C.: *Arch. Environ. Health*, 18:63 (January 1969)

Reference Committee "G"

Winton H. Johnson, M.D., Chairman

Reference Committee "G" met on Sunday, 17 May 1970, with all members present: Doctors Harold L. Colburn, Jr., C. Spencer Davison, Andrew G. Hudacek, Edward A. Jasionowski, and the chairman. Approximately 23 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees**—Items

Standard College Health Report Form (page 319)

There was some discussion concerning the second item in the "Resolved" portion of Resolution #79 submitted to the AMA by MSNJ's delegation to the AMA. This matter refers to the problem of submitting a physical examination form upon application to college, which necessitates, in the instances of many students, several examination forms being completed.

It was the opinion of the Committee that a standardized form might facilitate production of multiple copies, thus save the physicians' time of repeated examinations.

The Committee **recommends** that the report be approved.

Adopted

2. **Public Health** (page 370)

The Committee was informed by Doctor Farley, Chairman of MSNJ's Special Committee on Child Health, that a revised Perinatal Study Guide recommendation was approved by the Board of Trustees three days ago. Report of the Board's recent action was not available to the Committee. Therefore, the Committee was not in position to act.

The Committee **recommends** that the report of the Council on Public Health be approved.

Adopted

3. **Cancer Control** (page 371)

It was noted by the Reference Committee—regarding the tumor registries—that it is not sufficient to have a collection of figures that in turn are not used for patient care or education.

The Committee suggests that the Special Committee on Cancer Control, through the Council on Public Health, take whatever measures are necessary to improve the use of the follow-up reports that physicians are asked to complete.

The Committee **recommends** approval of the report.

Adopted

4. **Child Health** (page 372)

The Committee **recommends** approval of this report.

Adopted

5. **Conservation of Vision, Hearing, and Speech** (page 373)

The Committee **recommends** approval of this report.

Adopted

6. **Environmental Health** (page 374)

The Committee **recommends** approval of this report.

Adopted

7. **Maternal and Infant Welfare** (page 375)

Recommendation #2 urges that all female patients on the contraceptive pill be seen by their physician every six months. Your Committee reflects the consensus of the discussants before it when it declares that it feels

that this recommendation is not necessary and may lead to legal complications.

The Committee **recommends** that recommendation #2 on page 376 be disapproved.

Adopted

The Committee further **recommends** that the remainder of the report be approved.

Adopted

8. **Resolutions:**

a. **Hazards of Air Pollution**—Resolution #14 (page 411)

The Committee **recommends** adoption of this resolution.

Adopted

b. **New Method for Reporting Maternal Deaths**—Resolution #18 (page 414)

The Committee **recommends** adoption of this resolution.

Not Adopted because it is unnecessary in view of the action already taken conjointly by the Department of Health and MSNJ.

c. **Stronger Program to Protect and Enhance Our Environmental Resources**—Resolution #24 (page 418)

The Committee was happy to note that action has already been taken on State level by the establishment of a new separate Department of Environmental Health.

The Committee **recommends** adoption of this resolution.

Adopted

d. **Health Education as a Curricular Component**—Resolution #26 (page 420)

The Committee feels that the members of The Medical Society of New Jersey should not only volunteer their cooperation but should make sure a standardized program is established on local level.

The Committee **recommends** adoption of this resolution.

Adopted

e. **Oral Contraceptives**—Resolution #34 (page 426)

The Committee **recommends** that the "Resolved" portion of Resolution #34 be amended to read:

RESOLVED, that the recommendations contained in paragraph 2 under the heading of "Oral Contraceptives" in the Maternal and Infant Welfare Committee report not be approved because the recommendation is unnecessary and undesirable.

Adopted

The Committee further **recommends** that the resolution be adopted as amended.

Adopted as amended by the Reference Committee.

Retardation Pamphlet

The President's Committee on Mental Retardation has published a new and different pamphlet on the mentally retarded. Entitled "Hello World!," it presents a case-history approach to those whose retardation is caused by deprivation and those who are retarded due to bio-medical causes. It describes what people can do—how parents can get information, how people can volunteer to serve the retarded, and how young people can plan careers in work with the retarded.

This brochure is available *gratis* to readers of this *Journal* by writing to the President's Committee on Mental Retardation, Washington, D. C. 20201.

Reference Committee "H"

Lorrimer Armstrong, M.D., Chairman

Reference Committee "H" met on Sunday, 17 May 1970, with all members present: Doctors W. F. Jones, I. N. Patterson, R. A. Taylor, E. H. Weiser, and the chairman. Approximately 10 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees**—Items

FAA Medical Examination Form (page 320)

The Reference Committee reviewed the report and correspondence pertaining to the FAA problems. The Committee **recommends** that the AMA continue to work on this FAA problem.

Adopted

The Committee **recommends** approval of this report.

Adopted

2. **Annual Meeting** (page 327)

The Reference Committee wishes to commend the Committee on Annual Meeting for their scientific and technical exhibits as we feel the response this year has been quite satisfactory.

There was some discussion about the timing and the extent of the scientific program. It was felt that this matter should be referred to the Committee on Annual Meeting regarding the possibility of some changing to the time and extent of scientific programs at the future meetings of the Society.

The Committee **recommends** that this matter be referred to the Committee on Annual Meeting for study and possible implementation.

Adopted

The Committee **recommends** approval of this report.

Adopted

3. **Honorary Membership** (page 331)

The Committee **recommends** approval of this report.

Adopted

4. **Woman's Auxiliary Advisory** (page 347)

The Reference Committee reviewed the report of the Woman's Auxiliary Advisory Committee. The Committee was pleased to note that Sussex County now has a woman's auxiliary and that we now have 21 auxiliary units in The Medical Society of New Jersey.

We wish to commend the Auxiliary for their interest and programs, and for the aid they have given to the Society.

The Committee **recommends** approval of this report.

Adopted

5. **Nominations for Emeritus Membership** (page 399)

The Committee **recommends** approval of this report.

Adopted

6. **Resolution:**

a. **MSNJ Convention Format**—Resolution #15 (page 412)

Resolution #15 was discussed in detail by Doctor Chamberlain and Doctor Kaufman of Essex County.

The Committee **recommends** that Resolution #15 be not adopted but be referred to the Committee on Annual Meeting for study.

Adopted

The chairman thanks the members of the Committee and the other physicians who participated in the discussions.

Reference Committee on Constitution and Bylaws

Francis A. Pflum, M.D., Chairman

Reference Committee on Constitution and Bylaws met on Sunday, 17 May 1970, with all members present: Doctors James E. D. Gardam, Peter H. Marvel, George O. Rowohlt, Joshua N. Zimskind, and the chairman. Approximately 7 delegates and members were present to discuss the various items under consideration.

1. **Chapter II—Meetings, Section 3—Rules of Order** (Exhibit #1, page 344)

The Committee **recommends** that this proposed amendment to the Bylaws be amended to read as follows: (amendment indicated by italics)

The deliberations of this Society shall be governed by parliamentary usage as contained in *latest revision* Sturgis' "Standard Code of Parliamentary Procedure," when not in conflict with the Constitution and Bylaws.

The Committee **recommends** that the proposed amendment be adopted.

Adopted

2. **Chapter V—Procedure of Election, Section 1—Nominating Committee** (Exhibit # 2, page 344)

The Committee **recommends** that this section of the Bylaws be amended to read as follows: (amendment indicated by italics)

(b) The elected member of the Nominating Committee, or in his absence the alternate member of the Nominating Committee, shall present his credentials to the Secretary *before the scheduled meeting of the Nominating Committee.*

Adopted

(c) The Immediate Past-President of this Society shall be a member of the Nominating Committee representing the Fellows *and shall serve as Chairman.* If he shall not be able to serve, *his immediate predecessor shall serve in his stead.* He shall forthwith present his credentials to the Secretary.

Adopted

(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the Nominating Committee. This Committee shall meet *at least four to six weeks* prior to the opening session of the House of Delegates *at a time and place designated by the Chairman. The report and results of the Committee's deliberations are to be circulated to the component societies by the Chairman and* to the House of Delegates in the form of nominations for each of the offices to be filled, including Trustees, elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations.

The Committee **recommends** that the foregoing proposed amendments be adopted.

Not Adopted—By action of the House the foregoing item (d) was recommitted to the Committee on Revision of Constitution Bylaws.

3. **Chapter V—Procedure of Election, Section 3—Report and Election** (Exhibit #3, page 345)

The Committee **recommends** that the proposed amendment be adopted.

Adopted

4. **Chapter VII—Judicial Council, Section 4—Duties of the Judicial Council** (Exhibit #4, page 346)

The Committee **recommends** that the proposed amendment be adopted.

Adopted

5. **Chapter XI—Component Societies, Section 4, Associate Members** (Exhibit #5, page 346)

The Committee **recommends** that the proposed amendment be adopted.

Adopted

Report of Nominating Committee and Election—May 17, 1970

John F. Kustrup, M.D., Chairman

OFFICE	TERM	NOMINEE AND COUNTY
President-Elect	1 year	E. Vernon Davis, M.D., Burlington
1st Vice-President	1 year	William J. D'Elia, M.D., Monmouth
2nd Vice-President	1 year	Matthew E. Boylan, M.D., Hudson
Secretary	1 year	Louis F. Albright, M.D., Monmouth
Treasurer	1 year	Samuel J. Lloyd, M. D., Mercer
Trustees:		
1st District	3 years	Francis J. Benz, M.D., Morris
2nd District	2 years**	Charles L. Cunniff, M.D., Jersey City
4th District	3 years	Harold L. Coburn, Jr., M.D., Burlington
5th District	3 years	A. Guy Campo, M.D., Gloucester
Judicial Councilor:		
3rd District	3 years	Albert F. Moriconi, M.D., Mercer
AMA Delegates:	2 years	Frank J. Hughes, M.D., Camden
	2 years	Jerome G. Kaufman, M.D., Essex
	2 years	John F. Kustrup, M.D., Mercer
	2 years	Luke A. Mulligan, M.D., Bergen
AMA Alternate Delegates:	2 years	Louis F. Albright, M.D., Monmouth
	2 years	John J. Bedrick, M.D., Hudson
	2 years	George L. Benz, M.D., Essex
	2 years	Nicholas A. Bertha, M.D., Morris
Delegates and Alternate Delegates to Other States:		
New York:		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	Peter H. Marvel, M.D., Atlantic
Connecticut:		
Delegate	1 year	Joseph A. Lepree, M.D., Union
Alternate	1 year	Josiah C. McCracken, Jr., M.D., Atlantic
Administrative Councils		
Legislation:		
2nd District	3 years	Louis Kosminsky, M.D., Hudson
3rd District	3 years	John B. Fuhrmann, M.D., Hunterdon
Medical Services:		
2nd District	3 years	James S. Todd, M.D., Bergen
3rd District	3 years	Karl T. Franzoni, M.D., Mercer
Mental Health:		
4th District	3 years	Edward A. Schauer, M.D., Monmouth
5th District	3 years	Miles E. Drake, M.D., Cumberland
Public Health:		
2nd District	3 years	Kendrick P. Lance, M.D., Passaic
3rd District	3 years	Thomas F. McLaughlin, M.D., Middlesex
Public Relations:		
3rd District	3 years	Howard D. Slobodien, M.D., Middlesex
6th Member	3 years	William N. Evans, M.D., Burlington
Standing Committees:		
Annual Meeting	3 years	Donald C. Davidson, M.D., Atlantic
Finance and Budget	3 years	John S. Van Mater, M.D., Middlesex
Medical Defense and Insurance	3 years	William J. D'Elia, M.D., Monmouth
Medical Education	3 years	John W. Nicholson, III, M.D., Burlington
	1 year*	Arthur Bernstein, M.D., Essex
Publication	3 years	Daniel B. Roth, M.D., Bergen
Woman's Auxiliary Advisory	3 years	Edward M. Coe, M.D., Union

* Elected to fill unexpired term.

** Nominated and elected by the House to fill unexpired term of Matthew E. Boylan, M.D., who resigned upon being elected 2nd Vice President.

Adopted as amended

GENERAL SESSION

Saturday Afternoon, May 16, 1969

The General Session was convened at 4:00 p.m., Nicholas A. Bertha, M.D., President, presiding.

Dr. Bertha: I think the program you are about to hear is of a great deal of interest to all and after the papers are given you can have a question and answer period.

The program that we have today is on Medicaid. We have three speakers, Dr. Bertram Bernstein, Mr. William C. White, and Dr. Herbert Kerr. I would like to ask Dr. Herbert Kerr to speak first. He is a Special Assistant to the Commissioner, Medical Services Administration, Social and Rehabilitation Services, Department of Health, Education, and Welfare in Washington.

Dr. Herbert H. Kerr: Distinguished Members of the House of Delegates, Ladies and Gentlemen: I bring you greetings from the new commissioner of the Medical Services Administration, Mr. Howard N. Newman. As some of you may know, Mr. Newman is a Fellow of the American College of Hospital Administrators and has been an outstanding administrator for many years. He came to the Department of Health, Education, and Welfare from the Pennsylvania Hospital in Philadelphia and before that he was on the administrative staff of the Roosevelt Hospital in New York City. He brings a wealth of practical experience to the Title XIX program as well as tremendous dedication and great energy which are needed in unlimited quantities in these difficult times.

Medicaid is now four years old. In that relatively brief span of time a unique, nationwide structure has been developed combining Federal, state, and local resources. The purpose is to finance health care for a substantial segment of our population, a segment generally unable to pay for it. For example, in 1969, Medicaid paid for medical and remedial services for almost 13 million needy people; spent nearly $5 billion of Federal, state, and local funds for those services (about 10 per cent of the Nation's total expenditures for personal health care); and revealed that our health care system may not be as good as we thought it was. Of course, there is no single national medical assistance program, although we speak of Medicaid as if there were. Instead there is a series of partnerships between the Federal government and the individual states. Within certain broad Federal requirements each state administers its own Medicaid program, chooses the amount, scope, and duration of the medical care and services offered, and finally decides which groups of people will be eligible.

At present there are Medicaid programs in 52 of our 54 jurisdictions: 48 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The only states without Medicaid, Alaska and Arizona, have some special problems in that the Federal government has traditionally taken care of the medical needs of their relatively large Eskimo, Indian, and other native populations without asking for any contribution of state funds. This points up the fact that each state draws up and runs its own Medicaid program, according to its own needs and finances. HEW approves each plan after determining that it conforms with the requirements of Title XIX.

My little department, the Medical Services Administration in HEW's Social and Rehabilitation Service, is charged with the responsibility of running the program from the Federal level. We discharge our responsibilities through nine—soon to become ten—regional offices. We also issue regulations and guidelines to implement policy and make periodic checks on state program operations. The regions will soon pick up this responsibility. MSA also consults with the states and advises them on specific problems.

We started out with about 25 people in the Central Office in 1966—the first year of the program. We have increased about 25 each year since then and I have just been advised that we now have 125 on board—to manage

52 separate plans and spend close to $3 billion of Federal funds.

We do not actually pay any individual physician or facility. The states do this and are reimbursed by the Federal government on the basis of their average per capita income level. The Federal share ranges from 50 per cent in the most prosperous states to 83 per cent in the poorest.

It is our responsibility to help states develop and improve Medicaid programs that comply with a broad range of Federal requirements. Among other things, states must develop controls to ensure that Medicaid pays bills for medical care only—for services included in their plan, for services medically necessary, for services actually provided, in the proper amount and without duplicate payments. So you can see that there is quite a lot for us to do to help states really manage their programs properly.

Rising costs have been and are one of our major problems, and I could spend the rest of the day talking about the troubles we have had with financing. But I can also tell you that I feel we may have reached a point of stability in this regard, and one of the happy moments was when we saw that Maryland was successful in controlling its program to the extent that it can probably turn back about half a million dollars to its state treasury this year. In years past Maryland ran quite a deficit.

During the past year we have also had the good advice and counsel of several very fine advisory committees which have a number of physicians on them, so this organization does not function in a blind as far as professional advice and guidance is concerned. Our Medical Assistance Advisory Committee has seven physicians on it and our Nursing Home Advisory Committee has two. We think that a lot of good advice has come from these committees and the changes that may be made in the program will reflect some of their deliberations.

Regulations issued in July focused on costs of inpatient hospital care and reimbursement of physicians and other practitioners. In regard to inpatient care, an allowance for unidentified costs in the formula used for computing care costs (2 per cent for non-profit, 1.5 per cent for proprietaries) *was eliminated.* It was felt that the allowance was no longer needed as hospitals should now be able to identify and bill for all costs. I think we can look forward in the next couple of years to a very great deal of emphasis on cost accounting in all activities, not just medical, and I think we will have some very elaborate and, on the other hand, uniform cost accounting systems prescribed for us.

Also, Medicare's Bureau of Health Insurance has recently drafted proposed regulations to implement the addition of 8.5 per cent to routine nursing costs for aged, pediatric, and maternity cases. This, after application of the cost reimbursement formula, would result in the recognition of additional costs related to Medicare beneficiaries. In this regard, there are several suggested alternative positions. One of these alternatives points out that the introduction of this proposed specialized factor of reimbursement under Medicare presents an opportunity to divorce Medicaid reimbursement from Medicare reimbursement by permitting states to define reasonable costs subject to guidelines and approval by the Secretary. In other words, some of the flexibility in the Medicare program resides in the Medicaid program. Of course there is always some question as to whether this can be accomplished administratively or whether it would require legislative action. Apparently some of this does require legislative action and I'll get to that later.

There is much support for seeking new methods of reimbursement for the costs of health care. Congresss has stressed the need for innovation in methods of payment for inpatient hospital services that will create incentives for efficiency and economy.

Our Under Secretary, Mr. John Veneman, has

said: "Neither the reasonable cost nor the reasonable charge criteria established in the law have provided opportunity for major cost control efforts. I believe that it is now time to make some fundamental changes in the law which governs medicare and medicaid reimbursement. We need an incentive system of institutional reimbursement.

"I think we should now move as quickly as possible in the direction of determining reimbursement *prospectively,* instead of retroactively. With rates set in advance, a provider would be challenged to stay within the limits of the known reimbursement to be received and the provider would share in savings that come from economies that are achieved through effective management. Thus, economic incentives for efficiency and economy in the rendition of services would, for the first time, be introduced into the program's method of payment. In this way we would harness the ingenuity of the thousands of managers and policy makers in our health institutions to the objectives not only of quality care but effective and efficient management.

"We are examining a number of ways in which such an approach could be implemented."

The regulation on reimbursement of physicians and other practitioners, issued as interim policy, related ceilings for Medicaid payments to the 75th percentile of customary charges in the community as of January 1969. It also pegged increases in reimbursement ceilings to increases in the over-all cost of living as computed without the medical care component. Changes like this in the law have to be made in state plans, they are not just made at the Federal level, and approval of such state changes will require development by the state of utilization review procedures that are satisfactory to the Secretary.

Later last summer, new legislation amended Title XIX to make it legal and possible for states to reduce the scope of their Medicaid programs to prevent cost increases, provided they were fully complying with their utilization review and cost control plans. This was brought on by some difficulties they had out in New Mexico and their senator, Senator Anderson, proposed amendments which also advanced from 1975 to 1977 the date when all programs must offer comprehensive care to all those eligible.

Other proposed changes require additional congressional action. Several relevant proposals have been forwarded by the Department to the appropriate congressional committees. In general, these proposals reflect growing interest in new kinds of prepayment plans and continuing emphasis on comprehensive areawide planning in order to promote optimum balance among all kinds of services and levels of care.

Just two days ago, H.R. 17550 was reported out from the House Ways and Means Committee. It has not yet appeared before the whole House, nor has it gone to the Senate. I don't think that it will be passed in exactly the form in which it is written but it has some very interesting points, including many of those which I have mentioned.

About 7 out of every 10 Medicaid dollars have been going for institutional care, with close to 30 per cent for nursing homes and close to 40 per cent for hospital inpatient services. Physicians in general get something around 12 or 15 per cent; pharmacists about 7 per cent; dentists 5 per cent, and miscellaneous the rest. This being the case—and I am referring particularly to the high users, the nursing homes and the inpatient services—it behooves us all to think in terms of increasing the availability of preventive and outpatient services with a view to reducing dependence on the more expensive forms of care.

We will be hearing more about these proposals as the year progresses, and more about utilization review, which is, of course, basic to making the most efficient use of our resources for the benefit of all our people.

Thank you very much.

Dr. Bertha: We will next hear from Mr.

White of Prudential Insurance. Mr. White is the Vice-President, Governmental Health Programs Department, Prudential Insurance Company of America, based in Newark.

Mr. William C. White: Four years ago I appeared before you to discuss the Medicare program which was to become effective on July 1, 1966. As we prepared to implement this massive Federal program, many states were preparing to implement another program known as Medicaid, a state administered program with shared financing with the Federal Government. New Jersey, as you know, proceeded cautiously and did not have a Medicaid program until January 1, this year. The subject of today's meeting is Medicaid, but Medicare and Medicaid are so inexoricably joined in their implications for the people of this country and for the medical profession, that I feel compelled to discuss both programs in their broad national context rather than to limit my discussion to New Jersey Medicaid.

It is important to remember that both Medicare and Medicaid have their origins in the same legislation, the Social Security Amendments of 1965. Medicare was established by Title XVIII and Medicaid by Title XIX of the Social Security Act. Although eligibility, benefits, administration, and financing of the two programs are completely different they are joined as one in the minds of Congress, the public, and the press. I know from personal experience in appearing before Congressional Committees that this melding of the two programs exists and that more and more it is felt that the two should operate under the same rules, especially in the determination of benefits to be paid, both as to amount and as to appropriate utilization of services. Decisions made for these programs undoubtedly will have far reaching consequences in the expansion of public programs in the health care field.

As you are well aware there has been mounting criticism of Medicare and Medicaid especially with respect to the amounts paid for physicians' services. These critical remarks have been spread throughout the news media and the most recent devastating blast was a direct result of a report by the staff of the Senate Finance Committee, released in February of this year. This report was a follow-up of hearings held last summer and a continuing investigation by the Finance Committee staff. Another important development, as a result of the Finance Committee's critical remarks of last summer, was the appointment by the Secretary of Health, Education and Welfare of a Task Force on Medicaid and Related Programs, of which I am a member. The Task Force will submit its final report to the Secretary next month.

Although the Senate Finance Committee Report and their recent hearings, and the Task Force deliberations, cover a broad range of matters related to Medicare and Medicaid, I will limit my discussion to the one of most immediate interest to you, i.e., physicians' services.

Title XVIII-Medicare—provides for payment of reasonable charges for covered physicians' services. It states further "In determining the reasonable charge for services . . . , there shall be taken into consideration the customary charges for similar services generally made by the physician . . . furnishing such services, as well as the prevailing charges in the locality for similar services." It states further, however, that the charges considered as the basis for benefit determination shall not be higher than the charge applicable, for a comparable service and under comparable circumstances, to the policy-holders and subscribers of the carrier. This, then, has been the basis for determining benefit payments under Medicare and, in fact, in many states the same approach was used in Medicaid.

Physicians' charges rose at a much more rapid pace than did the Consumer Price index in 1966, 1967 and 1968. The costs of Medicare Part B and Medicaid increased substantially over the actuarial projections. As a result of the rapidly rising costs of these public programs, charges and countercharges as to the cause were generated in government circles, in the press and other public forums. As HEW Secretary Cohen left office he froze the

Part B premium rate, forcing the Social Security Administration to freeze the customary charge screens and the prevailing charges established by the Medicare carriers. On July 1, 1969 a similar freeze was applied to Medicaid. The debate continues about what further actions should be taken by the Administration and by the Congress.

The Senate Finance Committee is taking a strong stand that the law, as I quoted to you earlier, with respect to the determination of reasonable charges, has been misinterpreted by the Social Security Administration and the carriers. It is their position that the statute merely intended that customary and prevailing charges be taken into consideration but that other factors are equally, if not overridingly, important. The factor that has emerged as the most important is the local Blue Shield schedule, especially if that schedule represents a service benefit with income limits above the general level of income of the beneficiaries of public programs.

In the Finance Committee report, there is the following quotation from testimony presented by the National Association of Blue Shield Plans before the Committee in 1965, when the Social Security Amendments of 1965 were under consideration: ". . . even in 'indemnity plan areas' the Blue Shield schedules generally reflect the prevailing charges in the community. Therefore, (including service benefit plans) an increasing percentage of claims are satisfied in full by the Blue Shield payment. As you know, there is a growing tendency among physicians throughout the country to stabilize their fee schedules and to accept the same fee for similar service from all patients regardless of income . . ." This quotation is a focal point for the Finance Committee's continuing criticism of Medicare and Medicaid payments for physicians' services.

The representatives of the National Association of Blue Shield Plans, in questioning before the Senate Finance Committee on April 14, pointed out that, in recognition of the fact that Blue Shield schedules are outmoded, the Plans have been moving over the past few years to a customary fee approach. They did their best to justify the payments made under Medicare and Medicaid as representing the customary fees of physicians, despite the statements made by the Association in 1965, but I'm afraid that the witnesses were hoist with their own petard, not only by their past statements but by the fact that the scheduled benefits are still recognized by a majority of physicians as participants in the Plans.

I also appeared before the Senate Finance Committee on April 14, 1970 and one of the principal points made to me was that in New Jersey the Prudential as the Part B carrier for the State recognized higher charges, as customary charges of physicians, than the Blue Shield schedule. This is true. The Committee had a chart, which also appears in the report, comparing our average allowances with the Blue Shield schedule. My defense was that the Social Security Administration and the private insurance companies serving as Medicare carriers took the position in 1965, and continue to stand by that position, that Blue Shield schedules do not necessarily represent the customary charges in a given community. Under private insurance programs we have, both before and after Medicare, experienced quite a difference in charges as compared with local Blue Shield schedules and have recognized them, within reason, as the going rates.

I believe in my position and I have stated it repeatedly in many public forms, as, for example, before the New Jersey Legislature when the Medicaid legislation was under consideration, before the HEW Task Force, in meetings with the Social Security Administration, at hearings before the Ways and Means Committee, and in other public forums. But I'm always confronted by the statement that a majority of the physicians are participating physicians in Blue Shield and, therefore, why should the government pay more?

The HEW Task Force report will contain recommendations for control of the cost of benefits for physicians' services. The Ways and Means Committee has approved a bill

limiting Medicare benefits to the 75th percentile of physicians' customary charges for fiscal year 1971 with increases in future years limited to some percentage based on an index reflecting increases in the cost of doing business. When that bill reaches the Senate, I predict even more stringent rules for both Medicare and Medicaid possibly limiting the maximum payments to a schedule such as the local Blue Shield schedules.

All of these developments are important, not only for their immediate effect on current payments under Medicare and Medicaid, but because precedents are being set and conclusions reached that will influence the course of National Health Insurance proposals which will receive increasing consideration in the political arena.

Under New Jersey Medicaid, the level of payment for physicians' services is a policy matter within the jurisdiction of the Department of Institutions and Agencies and its Board of Control. As the fiscal agent of the Department we operate under their rules. Because there is a substantial amount of state money involved, the Department must be sensitive to the feelings of the legislature. The adverse publicity about physicians' charges in Medicare and Medicaid will not go unnoticed in state legislative circles. I hope that our State program can operate so successfully as to offset some of the effects of national criticism.

In this regard, the administrative flow of work is important also. If claims are not processed promptly and accurately, all of us will be subject to the same criticism that has been directed toward many of the other state programs. If the environment is antagonistic because of administrative problems, there is bound to be a carry-over of ill will in the debates over policy issues. In fact, I believe that much of the adverse publicity about Medicaid costs has its foundation in poor administration. How can anyone believe that there is adequate review administratively of fees and utilization in a state program if in all other respects the administration has failed miserably?

There are some ways that you can assist us in the processing of Medicaid claims. For example, I urge you to be sure that the claims are submitted with all the necessary identifying data. Otherwise, there will be a delay in processing. Also, I encourage you to give a detailed description on the claim form of the services you have rendered. Our clerical staff evaluates each claim based on the information contained therein. The more detailed the information, the more accurate will be the evaluation. A single word can sometimes make a difference in the amount of payment. While on the subject of claim forms, I would remind you that claims on patients who also have Medicare coverage should be submitted on the Medicare claim form, SSA 1490. As long as the Health Services Program number is shown, the claim will then be processed through both the Medicare and Medicaid systems with no further action required on your part.

We also seek your cooperation in leveling out as much as possible the "peaks and valleys" pattern of billing which we have witnessed in these first few months of the program. Monthly billing and, to some degree, even quarterly billing have caused us to receive large numbers of claims in the first week of the month and considerably less volume at the end of the month. Administratively, this uneven flow of receipts has been giving us some difficulty.

Claims on patients seen two or more times in a single month should be billed to us on one claim form. However, we encourage you to submit your other claims as often as possible during the month. A more regular pattern of receipts will enable us to operate the claim processing system more smoothly and keep the flow of payments even.

One other matter of concern in the Congress, and in other circles, is the subject of utilization of services. I cannot cover this serious problem adequately because of time limitations, but believe me it is the subject of much debate in HEW, the Ways and Means Committee, the Senate Finance Committee, and,

of course, in the news media. Obviously there is some truth in allegations that have been made about gross over-utilization of health service—it cannot be denied because there is enough evidence at hand—but, of course, there is also much exaggeration. Nevertheless, in any public program vigilance must be exercised to control abuses.

In order to avoid arbitrary controls I hope that organized medicine will assist the administrators of public programs in detecting and dealing with problems of both over and under utilization of health services. The Medical Society of New Jersey has recognized this need and has formed a joint committee with the Prudential Insurance Company known as the Joint Medicare Claims Inquiry Committee. We appreciate this action and intend to work with the Society to help assure public officials that private organization, such as the Medical Society and Prudential, can work together in the public interest to preserve our respective roles in private enterprise.

We do not intend to flood the Medical Society with claims because we know that the physicians who give of their time are doing so as conscientious men who believe in medicine as a profession and not as a trade, a position to which many of your critics would relegate you. We have guidelines to assist our trained claims personnel in the screening of utilization problems. We are fortunate to have on our staff a Medical Director and an Associate Medical Director who have been in private practice in New Jersey. These men guide our claims people in their work and review claims referred to the Medical Division. In turn, our medical men have available to them for consultation a panel of practicing physicians in New Jersey, all of whom are well qualified men representing all the major fields of medical practice. Obviously also, our medical directors have the opportunity to consult with other of their colleagues on the difficult problems referred to them. Most problems can be resolved satisfactorily through this procedure. Only after all these avenues have been exhausted will claims be referred to the Joint Medicare Claims Inquiry Committee.

On the other hand, I think there are other policy matters that should be discussed with the committee. I have tried to indicate to you that these are disturbing times with respect to the future of the delivery of health care and health care financing in this country. The public opinion polls show that for the first time a majority of the people—the voters, if you will—are in favor of some kind of national health insurance scheme.

Obviously, most of the respondents to such polls do not appreciate that government fiat will not reduce costs or guarantee quality health care; in fact, quite the opposite result probably will obtain. But no matter how often you or I may say this, our argument is based on an intangible proof—because no one will admit that the experience of other countries can be translated to experience in this country—and performance is the only argument that has any chance of success in such a debate. I believe, therefore, that we must work together on issues other than the specific claims problems of a given moment. We must attack such issues with vigor, with a willingness to cast aside past prejudices, with flexibility to meet the challenge of the times, and with a knowledge that the success or failure of the public programs that we have discussed today, and of private health insurance, is our joint responsibility. If we do not meet this challenge and responsibility, we both are doomed to be removed from the field of private enterprise.

I have presented some challenges to you today that may be unpleasant to contemplate. I did it deliberately. I choose not to talk only about the administrative problems of Medicaid because I believe the success of Medicaid and Medicare in New Jersey will be determined by bigger issues than those of administrative matters. I pledge to you, however, that Prudential will endeavor to the utmost to administer these programs efficiently and effectively, and that we will cooperate with The Medical Society of New Jersey.

You are faced with most difficult decisions, ones that have been difficult for organized medicine to face. You must consider a *consis-*

tent policy with respect to physician reimbursement, and means of assuring public officials — and the public — that organized medicine in the public interest is capable of controlling inappropriate fees and utilization of health care services. You in New Jersey cannot solve the problem alone because it is a national problem. But national policy for organized medicine is the aggregate of local policies. A cliché it is true, but time is running out. I wish you well in your deliberations because I abhor the thought of where we are heading today—and we are progressing toward that point at an accelerating rate—which is a National Health Insurance Program federally financed and federally controlled.

Dr. Bertha: Thank you very much, Mr. White.

I have been talking with Dr. Bernstein and we have discussed whether we would rather hear a presentation from him or have questions from the floor. We decided that perhaps we'd just have questions.

Before we get to that, we have a gentleman in the audience who has been quite vociferous in his discussion of Medicaid. He has written several letters to the Trustees. He also has requested that I let him have a microphone. So, Dr. Reilly, I'll give you a microphone for three minutes. At that time I'll give you notice to hang up. Dr. Reilly of Union.

Dr. John J. Reilly (Union): My comments probably will be a little general but they pertain predominantly to the matters under discussion here today.

Three years ago we broke tradition in New Jersey to some degree. We requested payment for welfare patients. We presented a resolution from Union County to our House of Delegates and the House of Delegates unanimously approved that such a program be worked out. Our representatives worked out some type of arrangement with the State Department of Institutions resulting in an 80 per cent reimbursement. The figure was not meager and we were not averse to such a settlement but in principle it seemed that the mandate from this House was not for a percentage arrangement.

Accordingly, two years ago we came back with another resolution—looking forward to Medicaid—and it was requested at that time that no arrangement be made with Medicaid that did not have the universal approval of this House of Delegates, even if it required holding a special meeting of the House.

Now we are five months into 1970 and five months into Medicaid. I don't recall any literature that came to us. I recall no request for a special meeting of the House of Delegates. As a matter of fact, we are currently into this meeting and we still have no fee schedule, no fee arrangement with Medicaid.

I can give you a little example of some of the problems with this. Ten days ago a local anesthesiologist, Dr. Moss, from Elizabeth, called the Department of Institutions and Agencies regarding a fee for Medicaid payment. He was advised that there was no fee schedule available and he said, "Well, how shall I bill for this patient?" He was told that he could try the Blue Shield prevailing fee schedule. He said, "Well, I have been up all night with this patient and the Blue Shield fee is fifteen dollars." The reply to him was, "My heart bleeds for you." And then the physician hung up the phone. He called back a short time later and apologized for his attitude and they discussed the matter further, and the physician was told that in essence there is no fee arrangement and he asked "How are we going to bill?" The reply was: "This is a secret. We are not giving out any type of arrangement to you."

Now, gentlemen, I'm calling upon this House to stand behind our resolution two years ago. I think whatever arrangements are going to be made should have the approval of this House. They should not be made by a small committee, by one or two representatives, and I can sense the veiled threat of the gentleman that just addressed us. I realize that we have problems in escalating costs, but still there are seven thousand physicians in this state, or

more, who are not paid employees and I think we have a voice, too.

Dr. Bertha: Thank you, Dr. Reilly. Dr. Bernstein, would you like to answer him?

Dr. Bertram M. Bernstein: I'm acquainted with the resolutions that Dr. Reilly mentioned several years ago. As you may recall, that was in association with the inauguration of the Medical Assistance for the Aged Program—this 80 per cent arrangement, where we would pick up the deductible under Medicare, whether the individual was covered or not, but we would not pick up the 20 per cent co-insurance. This was the first break in that this was the first time that Welfare paid physicians *anything* for their services to patients in the *hospital*.

Concerning your second point, I know Dr. Moss. He was down in Trenton several times and he is on one of our technical advisory committees. I find it hard to believe that anybody in our office would say anything such as you have quoted—I find this hard. Anyway I accept it and I certainly will check on it insofar as the fifteen dollars and the fact that he stayed up all night and so on.

We do not have a fee schedule. This House of Delegates last year indicated that if the state, in establishing the Medicaid program, came up with anything other than a usual and customary type of structure I believe the House was to be called into session. There were several meetings with Dr. Bertha, Dr. Satulsky and other members of the Board to try to work out some agreement. You see, you had the Legislature insisting that there be a fixed fee schedule and the Medicaid Commission, which, according to the law, is composed of the President of the House, the Speaker of the Assembly, the Governor, the Treasurer, and the Commissioner of the Department, was to determine fees, and then, finally, you had the Board of Control of Institutions and Agencies. Anyway, as a result of much deliberation a fee structure was worked out. It was not a fixed, rigid fee schedule.

Now, we don't know in Trenton, and no employees can actually know, what any physician is going to get for any particular service, because fees differ. A fee is dependent upon the region, it is dependent upon the physician's field, it is dependent upon the prevailing fee in the locality, and it is limited by the Secretary of HEW's ruling that the fees cannot exceed the 75th percentile as of January 1 of last year. All these are taken into account. This does not in any way mitigate the fact that Dr. Moss was very abruptly handled. I say there is no excuse for that. But if there is any problem relative to physicians' fees Prudential is the one to contact. Prudential knows what the fees are. They are built into the computer and, as I said, we don't know.

We had a physician call the other day and, surprisingly, he had just had two hundred claims rejected. He was an obstetrician. They were not rejected because of the fee per se. They were rejected because this was a group of several obstetricians and the individual performing the service had not signed. Well, this, as you know, is quite impossible in any partnership where one man will be in the office one day and the other will be in the hospital. They don't even know which one delivered the patient. This is why the claims were rejected—they had the corporation number down and did not identify the individual. This means that we immediately have to determine a policy and instruct Prudential on this. Prior to now, at the initiation of the program, we would not pay corporations at all. This was a proscription given to us by the Board of Control. There were complaints brought up from individual physicians to the State Medical Society, from the State Medical Society to us. We worked out an arrangement whereby either solo practitioners who have incorporated or multi-disciplinary groups or whatever could receive payment—a check directly from Prudential on behalf of all of the members of the group as long as we could identify who it was rendered the service. These things we can work out when we know about them.

I don't know if this answers your question,

but such things are going to be coming up constantly as the program develops. You know, the program got started January 1. It got off very quietly. In the first place it was New Year's Day and the next day was a state holiday. Another thing, we had moved the week before and no one knew where to find us. We wondered why it was so quiet for two weeks, then we discovered that although we had telephones no one had told the State House operator where we were. We had 25 local offices that weren't established and didn't have telephones. We had local consultants who were picking up the mail from the post office box and taking care of authorizations in their home. I mean we got off the ground.

Dr. Bertha: Dr. Reilly, as Dr. Bernstein told you, we did not call a special meeting of the House of Delegates because there was no question that we were going to get reasonable and customary fees. This is what we discussed and this is what was agreed upon. On the other hand, when they cut us to the 75th percentile as of 1969 we couldn't do a thing about it. We did everything we could do to get exactly what the House of Delegates wanted us to get and this is what we did get, but the 75th percentile is established by people who are outside of our control, and we can't do a thing about it. The only thing you can do if you don't agree with them is not to accept Medicaid patients, and of course that's difficult to do, because being a doctor you just don't turn people away from your office. But, we did not turn down what the House of Delegates directed.

Dr. George T. Whittle (Monmouth): I think Mr. White's discussion here is an affront to our intelligence. I think he talks glibly in terms of free enterprise and everything else. Gentlemen, the fact here is that we have fixed fee schedules. If you had any dealings with the Prudential office, this is a "kangaroo" court. This is one-way discussion. Now, I have had a running problem with Prudential recently and I might say that I have spent two of the most frustrating days of my life trying to get some information from Prudential and to clear up some claims. You have been told that we are a free enterprise group, that we are trying to avoid government intervention, and that we are still free agents. Gentlemen, we no longer are. We are told what our fee schedules are. We are told what our fee schedules were a year ago, and now we suddenly find out that all our fee schedules have been cut when we are the only segment in the economy of this country that has been arbitrarily cut.

We are being told that the government is providing care for the Medicaid patient. They won't give us a schedule and they are going to pay us just exactly what they please.

Just to cite an example of how ridiculous this whole thing has become—I'm a urologist. I do some major urologic surgery. When we do an ileostomy procedure for a urinary diversion (because our hospital does not provide ileostomy bag appliances), I purchase these from surgical suppliers and bill the patients directly. My cost for these bags is thirty-four dollars. I recently had occasion to put one on a gentleman, and we got a fifteen dollar allowance from the Medicare program. My secretary called up and said: "Obviously, gentlemen, you have made a mistake. These bags cost us thirty-four dollars." They said: "Oh, I'm sorry." (They checked.) "No, we haven't made a mistake." So she sent them a letter with the brochure and the catalogue description and called them up again. This is now two letters and three telephone conversations. Their reply was: "We have determined by computer that the allowance for an ileostomy bag in Monmouth County is twenty-four dollars and, therefore, we are sending you an additional nine dollars."

Now, it just so happened that I had another patient who had an identical bag purchased through a surgical supplier. Medicare allowed $38.50. Well, we can't do anything that Medicare doesn't allow through Prudential, and vice versa. And I presented this and said, "Gentlemen, why are you so willing to pay $38.50 for an appliance that's purchased through a surgical supplier when you only

allow $24 for something for which I have a receipt for $34. I received two additional letters of correspondence from Medicare and this has not been clarified as yet.

Now, this is ridiculous—the whole management of this program, the fact that suddenly the claims are six months late and a patient comes into you and says: "Doctor, I have received notification from Medicare, through the Prudential Insurance Company, that you over-charged me fifty dollars on the operation." I explain that we made an agreement that this fee would be acceptable, that the patient would be responsible for twenty per cent additional, and that for the past two years this fee has been honored. Suddenly you are in the position where your patient says you are over-charging him.

I think if this body does anything it should insist that the public be informed that the government has reneged on its initial obligation and that its business is actuarially unsound in this area of rising costs, and it has done nothing to decrease our malpractice insurance, the cost of business, the cost of government employees, postage, and so on. I think that we must insist that the public be informed that the government has been financially irresponsible in its actions and that if it cannot live up to its initial obligations, it is not our fault.

Dr. Bertha: Thank you, Doctor. Mr. White, would you speak to that?

Mr. White: Well, of course, I can't speak to the specific claims' problems mentioned without the information, but I agree with the Doctor on what he ended up saying about the government program. In fact, in my own debates with Social Security and the Task Force I have been saying this very thing because it started out as a program which by law was to pay reasonable charges. In the beginning, before Medicare began, the insurance industry appeared before the House Ways and Means Committee and the Senate Finance Committee. We told them that the program was under-financed but, again, no one listens to anyone except other government officials and the government actuary said his figures were right. Anyone from private industry is suspect, and they wouldn't take our figures. Experience has proved we were right. But as always in any political program the Congress is going to try and hold the costs down. They have to pay for it, at the expense of someone else, of course.

One of my pleas has been that it is really hurting the beneficiaries, because this is an insurance program. It is not a program where the government is providing services; it is an insurance program. The doctor does not have to accept an assignment and by freezing the prevailing fees, and in fact even cutting back the definition of prevailing fees under this bill in the House now, you leave the burden on the elderly beneficiary, the one that all the Congressmen say they are trying to protect. And really, gentlemen, it is hurting that person who has little income and who thinks he is going to have enough money out of this program to pay at least 80 per cent of the bill. But, it is being cut back further and further. With this new bill that's going through—I'm sure it will pass this year—the best that will happen will be the bill as it now exists, defining prevailing as the 75th percentile, which is a cut back from where we are now. As I said in my talk, I expect in the Senate they are going to try to cut it back even more. And I agree that the people ought to be told what's going on, but this is a fact of life in a political program. That is why I said to you I abhor the thought of national health insurance, because, while they start out with a program talking about providing higher quality care and more protection, in the final analysis it becomes a battle of the budget every year, and without thought to what the consequences are as far as our rendering of medical care.

Dr. Bertha: We have some questions here and I will ask these of the panelists.

Dr. Kerr, did anyone check on the validity or accuracy of the figures and amounts published by the Senate Finance Committee?

Dr. Kerr: I presume you mean the report of the staff of the Senate Finance Committee wnich was published back in February, I believe.

Dr. Bertha: I believe that's what he is interested in.

Dr. Kerr: The thing is about half, three-quarters of an inch thick and there are many figures in there. I'm not aware which ones are in question.

May I say that in the beginning these figures did not necessarily come from our office. They come from a Bureau of Social Statistics, which are collected entirely independently and are often about a year or so late. The agency runs with a surprisingly small amount of current information.

Dr. Lloyd: Mr. Chairman, that is my question and I would like to point out to Dr. Kerr that at the time this was published it showed over-payments to doctors in New Jersey of a very considerable amount under Medicaid; and that Medicaid had been in existence in this state only a few months when these statistics already showed all these over-payments. I wrote the question prior to Mr. White's talk and I think he explained that down in Washington they are thinking in terms of Medicare and Medicaid interchangeably, and when they are talking about Medicaid over-payment maybe they were talking about Medicare over-payments. But, it was obviously ridiculous to the doctors in New Jersey because no such payments have yet been made in the State of New Jersey, yet the Senate Finance Committee lists payments—they didn't list all the payments that had been made but only the over-payments that had been made in a program which had just been initiated. I think it is important, if we are going to have any credibility to what's going on in the Congress at all, that they come up with better figures than they have.

Dr. Kerr: I certainly agree with you.

Dr. Bertha: Dr. Bernstein.

Dr. Bernstein: I purposely, Dr. Lloyd, didn't want to bring up any statistics at this time as to the Medicaid program because it's so new and there are a lot of claims that haven't been processed. It wouldn't be too significant except to say that we are staying within our budget. We are going to make it the first six months.

In relation to this point that you bring up, I was just handed on Thursday a print-out of the top 30 practitioners insofar as claims for the first four months of the year. The first man's name I recognize. These were not all physicians, incidentally, quite a few optometrists. But the first, the high reimbursement man, I recognized because I had been asked a year ago to check him out from HEW, because he was one of those who had earned more than $25,000. At that time I called him and he was very gracious and told me that he had employed four or five part-time physicians. They would come in for half a day a week in different fields and I assumed of course that he was doing the billing. His office was going from morning to night and he has quite a few technicians. So I immediately advised our statistical unit that when they come up with these lists I wanted them to be certain that these were charges by a single individual and not a group or a man whose billing was covering several others, because this high reimbursement has made a lot of headlines. One was, I think, a million and a half dollars to somebody in New York but this was corrected a little while later. This was a hospital. But the damage is done when this occurs.

Dr. Bertha: We have some other questions.

Mr. White, if a patient is covered by both Medicare and Medicaid did you say to bill on Medicare forms?

Mr. White: Yes.

Dr. Bernstein: Indicate in Section 5 the Medicaid number. You have to have the Medicaid and the Medicare number, then they are handled by Prudential.

Dr. Bertha: Is consumer education as to the limit of covered services considered adequate? What is being done to enhance and broaden the essential educational process?

Mr. White: In my testimony before the Senate Finance Committee I made quite a point about this because obviously people don't know what they are covered for, especially in the ECF benefits, but it's true throughout the program. Of course, both programs are very complicated programs if you look through the benefits and exclusions and the conditions under which benefits can be paid. Certainly this is so under Medicare, because you are dealing with elderly beneficiaries, a lot of them well past 65, not just 65, and it's difficult to explain the benefits and limitations to them, and even if you give them adequate literature they don't remember. I did urge that there be more effort made by the government to educate the patients by putting flyers in their Social Security checks, things like that, to help them understand the limits and not this continuing talk about the benefits.

Dr. Bertha: For Dr. Bernstein. This is a long one. Why should a doctor, taking care of a newborn whose mother is eligible under Medicaid, not be compensated for his care simply because the mother has not identified the father? To expect a physician to continally contact the Welfare Department until the child is finally assigned a number is in reality a non-payment for services that the public assumes is being provided.

Dr. Bernstein: This is a problem that will be corrected. One of the problems, one of the difficulties in New Jersey is that Medicaid is a completely state administered program whereas the Welfare programs, the categorical assistance programs—and essentially they are the persons who are covered under New Jersey's program—receive their funds and services and case work from the County Welfare Board. Under the Welfare program there was difficulty, as many of you may know, if you participated previously, because there was little uniformity from county to county. They had their own rules relative to medical care. So we wanted the State Medicaid program to be uniform. However, eligibility is determined by the County Welfare Board for Medicaid so we don't duplicate.

The problem here is that the mother is in the hospital. The hospital has the number, or if it doesn't it initiates an inquiry, if it is thought that this may be an ineligible person. That establishes the date. Subsequently, even if it takes the county a month or two months to determine eligibility, payment can go back to the date of the inquiry.

Now, if a pregnant female is in the hospital and delivers, there is really no mechanism to notify the county until the mother goes home and realizes that she should receive an extra allotment for food and so on for the child. Then, of course, she is going to call the county and report it. The county otherwise doesn't know about it. We were trying to work out a method whereby as soon as the child was born the hospital would notify the local medical assistance unit which would then notify the county and the county could then issue a person number. The case number would be the same. This hasn't been resolved yet.

I think one of the questions in this was what happens to the individual, the woman, the unmarried mother, who was not receiving assistance and is in the hospital and she delivers. She ordinarily would then become eligible for assistance for dependent children, but the county is holding it up because it wants to know who is the father. This is the issue. This is strictly a welfare problem. You see, Medicaid cannot pay unless a person is eligible, and we have nothing to do with the determination of eligibility except to try and get some more rapid communication and action by County Welfare Boards. This will be handled; this will be resolved.

Actually what I have told pediatricians who brought this to my attention was, "Don't send your bill in so fast. You are going to get

paid." But some physicians figure, well, they know that they have treated two children in the family and their personal number, say is 21, 23, so they will put down 25 or 26 as a personal number for this new child. Of course, the computer rejects it. They don't have any 26 in the computer. So the bill comes back. You'll save a lot of time just holding on. You don't have to keep calling. You will get paid if it's an eligible person.

Dr. Bertha: We will have two more questions here and then adjourn for the afternoon.

The first one is also to Dr. Bernstein, I'm sure. For the Medicaid patient receiving medical care in the OPD of the hospital only the hospital may bill for the services including those of the physician. Why can it not be arranged for the physician to bill directly and arrange to pay the hospital for use of the hospital facility?

Dr. Bernstein: If the physician is treating this patient as an ambulatory private patient then he can bill for the patient's care and then the hospital can bill him. But you cannot—say the physician is in the clinic, he is seeing 30 patients or 20 patients or 10 patients, two of them are Medicaids (the others are paying nothing or a token payment)—pull out Medicaid patients and say these are my private patients and submit a bill for those because you know that they have coverage. You cannot discriminate that way. Now, if the physician has an arrangement with the hospital (and we don't get into this) whereby he is paid not a salary but a stipend for his service during that session in the clinic, then the hospital can bill that amount of money into its costs, which it will receive and then it in turn can pay the physician. We have told the Hospital Association about this and I believe some of them are working out something like that. Then the physician would be getting paid on the basis of his care for anyone he sees in the clinic during that session he is there, not just the Medicaid patient. Again I say if the physician sees, in the out-patient department of the hospital, a private ambulatory patient who happens to be a Medicaid patient, he bills. And we wouldn't pay the hospital if the hospital billed us at the same time.

Dr. Bertha: The percentage distribution of benefits is very enlightening. What are the administrative costs as a percentage?

Dr. Kerr: I have some charts with me in my brief case here and I'll be glad to pass them out at the end of the meeting. I do not have any figure in my head, nor do I think such a figure has been determined either nationwide or statewide in terms of the actual administrative costs of the program. I tried to bring out the fact that a very few people are running this program at the Federal level and I speak only for the Title XIX program. I, too, have been to Baltimore and I have seen the thousands of people that are involved in Title XVIII. I am mildly envious of that. I don't know if they are all necessary or not. They seem to be getting in trouble, too.

Our administrative costs at the Federal level must certainly be a very, very decimal point type of percentage—125 people in terms of a program that is running better than three billion dollars in Federal money. The states undoubtedly run up other costs and there are some costs in the regions, although the regions only have about 100 people in all. The program does not seem to me personally to be top-heavy administratively. I don't think that's where the money is going, although I hear that from welfare rights people and even from some of the union people. Possibly Prudential has a figure on how much it costs them to run the progam here in the State of New Jersey.

Dr. Bernstein: I think it's too early because initially there were some start-up costs such as building, equipment, and so on. But I think we feel that the costs must be in the neighborhood of eight to ten per cent, no more than that.

DINNER DANCE

Mr. Richard I. Nevin, Toastmaster.

The Toastmaster: Ladies and Gentlemen, I am granting a dispensation to all to remain in your seats and to bow your head while I pronounce Grace.

(Grace Before Meals)

The Toastmaster: Now, Ladies and Gentlemen, before you become entranced with your fresh fruit cocktail, it is my pleasure to introduce Mrs. Edward O. MacDonald, President of the Woman's Auliliary, to extend to you an official welcome.

Mrs. Edward O. MacDonald: Thank you, Mr. Nevin. (Applause)

On behalf of the Woman's Auxiliary to The Medical Society of New Jersey, it is my privilege and pleasure to welcome you to the Annual Dinner Dance of The Medical Society of New Jersey honoring President and Mrs. Nicholas Bertha.

Thank you. (Applause)

The Toastmaster: There is a lady here tonight whom we are delighted to welcome, the Co-Guest of Honor, Mrs. Olga Bertha. (Applause) Because she has been so unwell, it was decided not to impose upon Olga the strain of being on the platform, but she is in the first place in our hearts. I shall not ask her to rise to greet you. Instead I suggest that you all rise to greet her. (Standing ovation)

(Introduction of Guests)

The Toastmaster: Ladies and Gentlemen, this is the moment of misty magic when before our eyes we see a President transformed into an immediate Past-President to receive his key as a Fellow, only to be transformed back again into a President, to enable him to carry out his final duties in the House of Delegates tomorrow.

But President, incumbent or past, Nick Bertha is a remarkable and wonderful guy whom it has been a privilege to know and an inspiration to work with. I think I can best illustrate my idea of his character by recounting for you an anecdote that I read concerning Lily Pons. It has to do with the time when she made her debut in Lucia Di Lammermoor in the Metropolitan Opera House, and those of you who are as old as I am, or older, will recall that she made a triumph. That evening in her home, after the critics' raves had been filed, her husband, Andre Kostelanetz, was running a party in her honor to which the critics and their friends had been invited. When the party was well under way, Madame Pons caught the eye of her accompanist and called him to her. She said, "Will you please bring the score of Lucia to the music room?"

And he said, "Madame Pons, why would you want the score of Lucia now?" He said,"You made a triumph in Lucia this afternoon."

She said, "I just want to see if there is any part of Lucia that I can really sing properly."

This is the spirit of Nick Bertha. He satisfies others far sooner than he ever satisfies himself. He has about him a divine discontent that drives him to do whatever he has to do as well and as wholeheartedly as he can. His year has not been easy, but his performance has been magnificent. For his earnestness, devotedness, idealism, thoughtfulness, and unfailing courage, I salute him. No matter what his office, he is always bound to be a standout and a man to be remembered and loved. (Applause)

And now, Ladies and Gentlemen, this is that moment of misty magic when he is to be inducted into the aristocratic fellowship of The Medical Society of New Jersey where the past-presidents may mingle together as peers and equals. For the honor of that induction we call upon Dr. John F. Kustrup, the immediate Past-President, to take Nick by the hand. (Applause)

Dr. John F. Kustrup: Nick, as immediate Past-President there are very few duties which you will be called upon to perform. There are very few moments that will equal those that you had as President. The members and the Fellows in their graciousness leave you this as one moment of glory. This is the moment in which the immediate Past-President presents the Fellowship Key to you as President. It gives me great pride to welcome you to this group. (Standing ovation)

Dr. Bertha: Thank you very much. I'm real proud to have been presented with this insignia inducting me into the Fellowship of The Medical Society. Thank you again. (Applause)

The Toastmaster: Well, Fellow Bertha, turnabout is fair play, and now it is your turn to bestow the Fellowette's Pin on Mrs. Edward O. MacDonald, the retiring President of the Woman's Auxiliary.

Dr. Bertha: I have been told Dr. MacDonald has his eye on me. (Laughter)

Mrs. MacDonald, it gives me a great deal of pleasure to be able to bestow upon you this pin, and I am told that I better be careful as to how I handle this (Laughter) And I have also been told that there are certain techniques involved in this . (Laughter) To the individual that told me that I told that I am very well experienced in this, having been in this practice for a few years. (Applause)

Mrs. MacDonald: Thank you very much, Dr. Bertha. And I didn't even get stuck. (Laughter and Applause)

The Toastmaster:I've been asked to tell you that we have some joyous news to share with you. We are informed that Dr. and Mrs. Emil Hornig, who are present here this evening, today had the great joy of having born their first grandchild, a boy. We congratulate you. (Applause) This may not be very popular now-a-days but it is interesting. (Laughter)

And of course we of the Board of Trustees can't forget the De Cecios who are going around with pigeon-pouted chests because their daughter and son-in-law were responsible for the birth recently of twin granddaughters. So to Dr. and Mrs. Tom De Cecio and their lovely offspring we extend congratulations. (Applause)

And just to be fair, if there are any more announcements of births, we'll be glad to welcome them. (Laughter)

This is not on your program, but I have a special request from the President of the Morris County Medical Society that he may approach this high dais, a very formidable place, to make a particular presentation. Dr. Seymour Kuvin. (Applause)

Dr. Seymour F. Kuvin: Some time ago Dr. Bertha came to his home society, the Morris County Medical Society, and told us of his travels and duties as President of The Medical Society of New Jersey and he concluded this speech by saying that it really took no time away from his practice. So we figured that Nick needed a new watch. (Laughter)

As a token of the admiration of his colleagues, members of the Morris County Medical Society, I would like to present Dr. Bertha with a watch which is engraved to read: "Nicholas A. Bertha, M.D., President, Medical Society of New Jersey, 1969-1970, from the Morris County Medical Society." (Applause)

Dr. Bertha: You know, I think I appreciate this almost as much as I do my Fellowship Pin because this is a complete surprise to me and I never expected it. I just can't say anything more. Thanks a lot. (Applause)

The Toastmaster: He will be surprised when he gets the bill for the Fellow's Pin. (Laughter)

Well, dear Ladies and Gentlemen, that concludes our program. We turn you over to the orchestra with the hope that you will have a delightful evening together which you will long remember with pleasure. (Applause)

THE AUXILIARY YEAR—1969-70

Saturday Afternoon, May 16, 1970

Mr. Speaker, Mr. President, Members of the House of Delegates and guests. Last year when Mrs. Kustrup returned to our meeting after making her report to the House of Delegates, she said, "You know I think they like us." Taken individually we certainly hope that was the understatement of the year. Taken as an organization we hope you not only like us but are proud of our achievements. The Auxiliary programs require a great deal of time and a great deal of work. Some programs also require money, and since very few Auxiliarians are independently wealthy, the programs do in fact become an extension of the Medical Society itself. I would like to thank your officers, Board of Trustees, Executive Director, and the staff of the Trenton office, particularly Mrs. Walsh, for their cooperation and support.

For the past year the theme of the Woman's Auxiliary to The Medical Society of New Jersey has been "Concern for Total Community Health Care." Realizing that trained, available health personnel is a prerequisite to the delivery of health care, the Auxiliary made Recruitment for Health Careers a high priority project. The program was a three pronged one: (1) recruitment and education of young people to health career opportunities; (2) indirect monetary support; (3) direct monetary support. In the field of education and recruitment, many of the component Auxiliaries held Health Career Days with relevant and interesting programs. The film "Horizons Unlimited" was shown at high schools, junior and senior, throughout the State. One County Auxiliary cooperated with its community hospitals' auxiliaries operating a mobile unit and visiting the schools in their area.

In the field of monetary support, the Auxiliary through its component auxiliaries has donated $9,983 to the Medical Student Loan Fund of the Medical Society of New Jersey, the Medical Student Loan Fund of a County Medical Society and AMA-ERF, for loans to Medical Students and aid to Medical Schools. In the field of scholarships and loans for nursing and ancillary services, grants have been made in the amount of $17,094. Total contributions, both direct and indirect—$27,077.

Our Community Health Committee has been another very active program. Several of our County Auxiliaries have sponsored Community Health Days or Forums. These have been both interesting and well received. Other counties have ongoing programs on Anti-Drug Abuse, Medic-Alert, Homemaker Service and Eye Screening. Auxiliarians also participated in Blood Bank Days and Measles Vaccine Clinics.

Through our Legislative Committee, auxiliary members have been actively concerned with all pertinent legislation, both state and federal. We have continued support of the Auxiliary to the Student Medical Association.

We are happy to report that a group of wives of members of the Sussex County Medical Society held a pre-organization meeting of the Sussex County Auxiliary, and requested permission from the Sussex County Medical Society to draw up bylaws. The request was approved and plans are now going forward for an organization meeting of the Woman's Auxiliary to the Sussex County Medical Society.

To those gentlemen whose wives have been actively engaged in Auxiliary programs, our sincere thanks—to those gentlemen whose wives are members but not actively engaged in the programs, we appreciate their support and hope they will participate further. To those gentlemen whose wives are not members, would you please urge your wife to join her county auxiliary. Our programs are varied, interesting, and meaningful. There is much work to do and the more hands we have, the better job we can do for you.

ATTENDANCE

REGISTRATION OF HOUSE OF DELEGATES

Registration:		
Total Possible — Officers, Fellows, and County Delegates		381
Total Possible of County Delegates	359	100%
Total County Delegates Registered	337	93.9%

Attendance of County Delegates at the House Sessions:		% of Possible	% of Registered
1st Session, 5/16/70	(302)	84.1	89.6
2nd Session, 5/17/70	(318)	88.6	94.4
3rd Session, 5/19/70 A.M.	(294)	81.9	87.2
P.M.	(268)	74.7	79.5
Average for all Sessions	(296)	82.5	87.8

Official Attendance Report

County	Delegates	Members	Total
Atlantic	7	43	50
Bergen	38	37	75
Burlington	9	14	23
Camden	21	30	51
Cape May	3	7	10
Cumberland	5	10	15
Essex	68	112	180
Gloucester	4	12	16
Hudson	27	18	45
Hunterdon	2	2	4
Mercer	24	34	58
Middlesex	16	40	56
Monmouth	19	41	60
Morris	16	22	38
Ocean	6	10	16
Passaic	28	29	57
Salem	3	11	14
Somerset	4	5	9
Sussex	3	1	4
Union	31	52	83
Warren	3	5	8
Fellows and Officers	20	—	20
	357	535	892

Physician Guests	82
Physician Exhibitors	15
TOTAL PHYSICIAN REGISTRATION	989
Auxiliary	403
Visitors	429
Exhibitors	272
TOTAL REGISTRATION	2,093

FIVE YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1970	989	1,104	2,093
1969	1,041	1,073	2,114
1968	1,112	1,176	2,288
1967	1,017	1,018	2,035
1966	1,024	1,135	2,159



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Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

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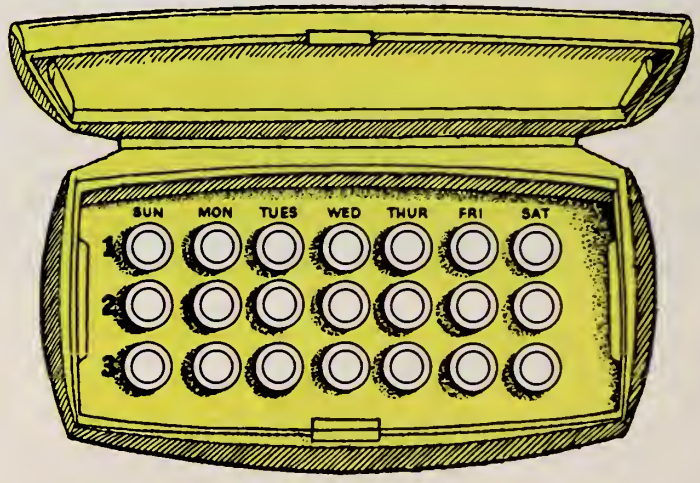
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Demulen—the one oral contraceptive that provides this new combination—offers • A full measure of confidence: Unsurpassed contraceptive effectiveness, and the low estrogen content—50 mcg.—is especially significant today • A full measure of comfort: A low incidence of breakthrough bleeding and other side effects.

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Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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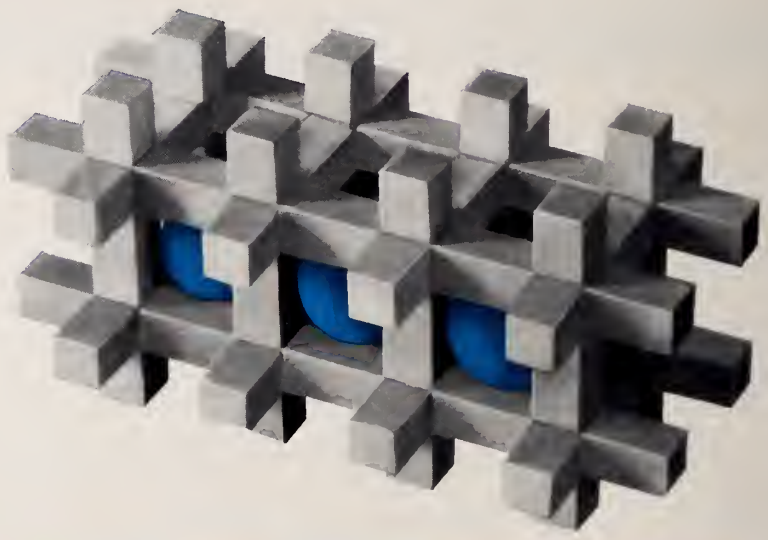
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Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

Warnings: Do not exceed recommended dosages.

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Adverse Reactions: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

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How Supplied: Bottles of 100, 500 and 1,000 tablets.

References: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al: Hosp. Topics 39:71-73, 1961: (3) Haas, Jr., J., and Kay L.L.: Southwest. Med. 42:30-32, 1961 (4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

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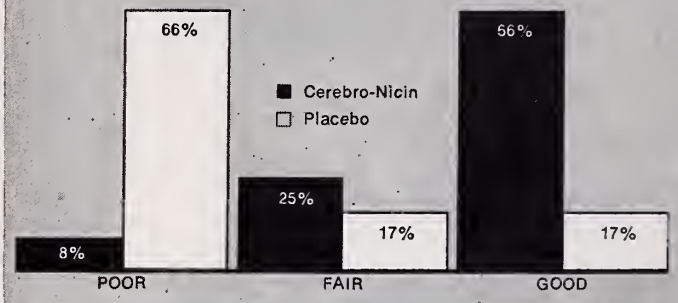
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

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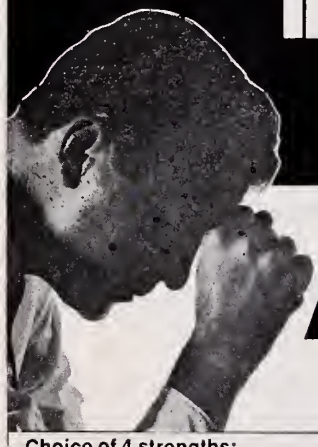
The treatment of

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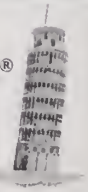
in the American male is complex. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study) T. Jakobovits Fertility and Sterility, January 1970 Official Journal of the American Fertility Society



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Contraindications – Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Trieff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Gradow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypothyroidism effect of androsterone. J Clin Endocr 19:936, 1959. 5. Ferris, E. J., and Colton, S. W. Effects of L-thyroxine and isothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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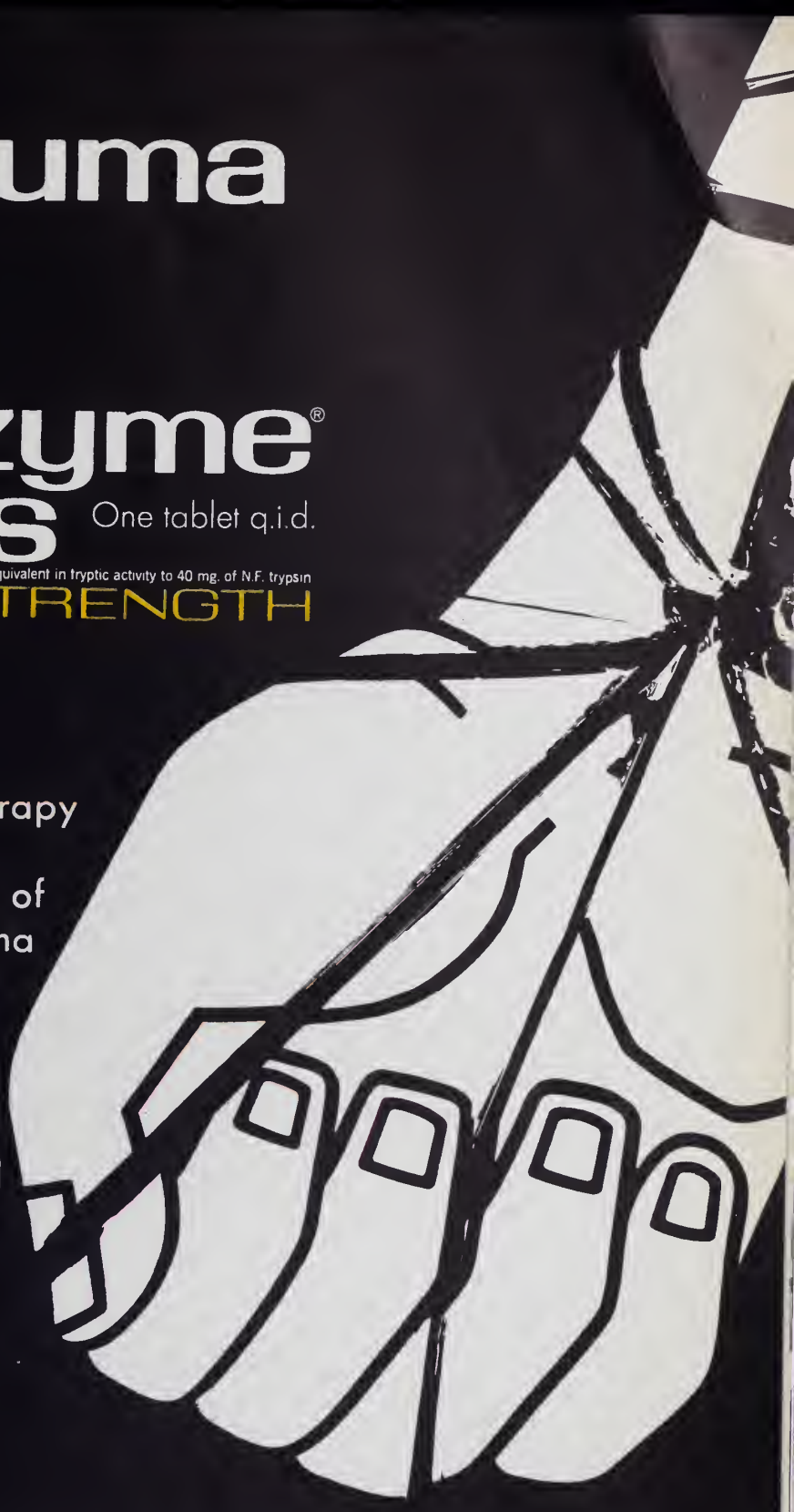
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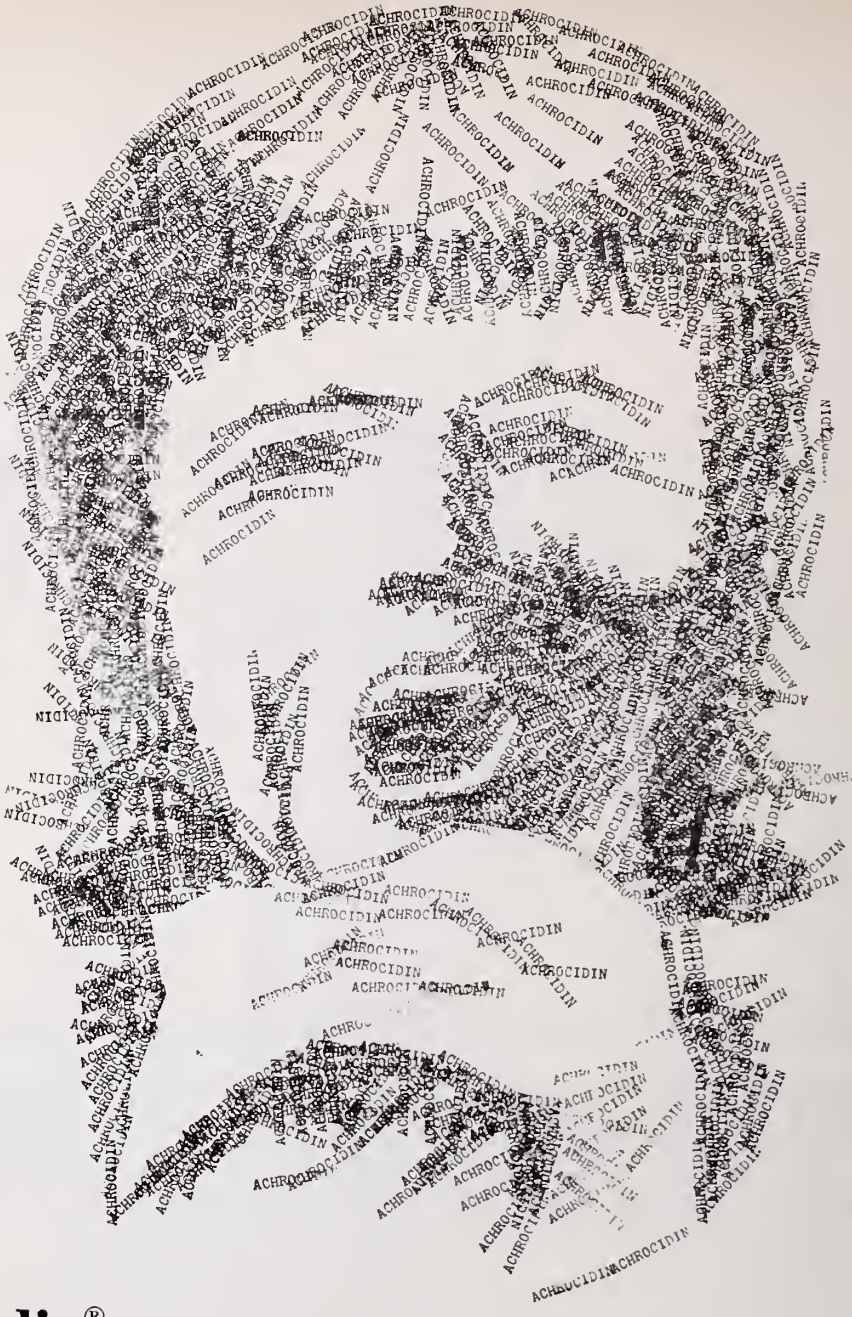
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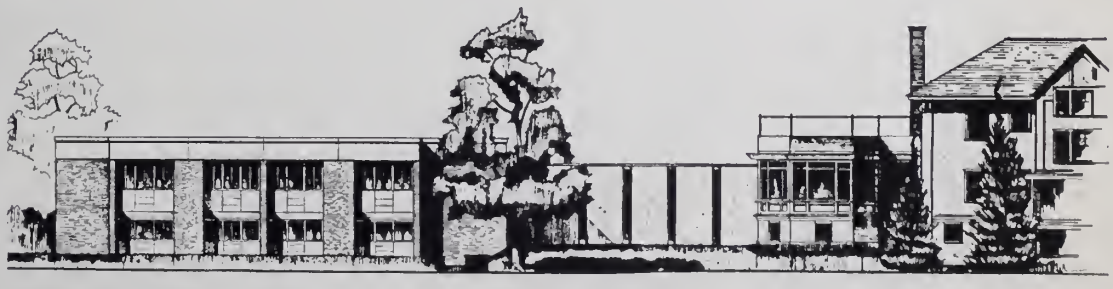
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A urinary tract infection was eliminated last week

Intestinal monilial overgrowth has appeared this week

For women who are diabetic or debilitated, oral antibiotic therapy often sets the stage for monilial overgrowth in the intestine.

When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

It doesn't let monilia begin where bacteria end. Declostatin® 300

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Effectiveness: Because its antibacterial component is DECLOMYCIN ® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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a new agent for the alcohol-dependent patient who wants to quit

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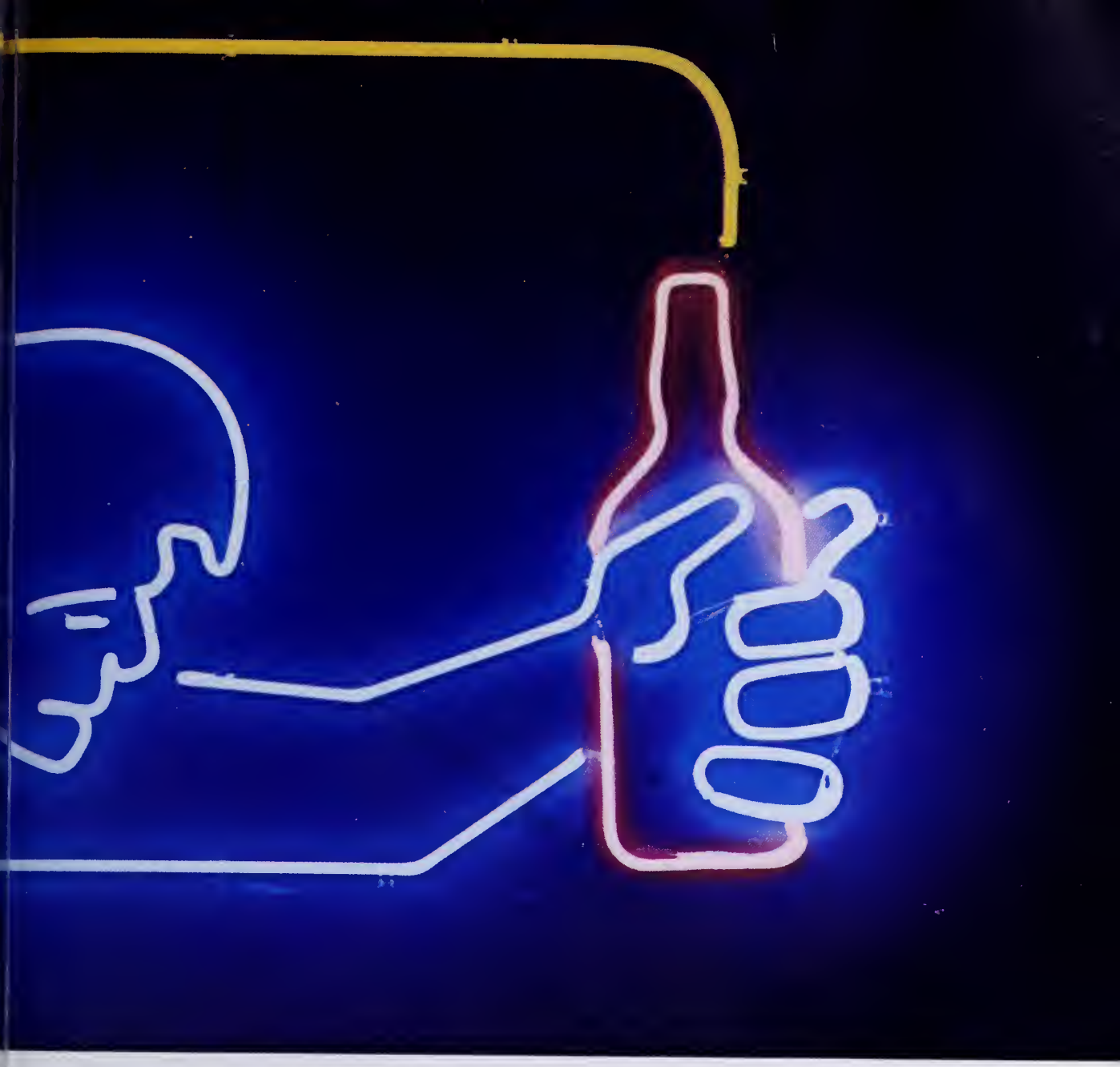
a program for the New Jersey physician who wants to help





a major tranquilizer with specific advantages for the alcohol-dependent patient

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
3. Antiemetic properties to control nausea and vomiting.
4. Has not caused hepatic dysfunction or interfered with functional recovery of impaired liver.
5. Four tablet strengths to allow flexibility of dosage (usual starting dose: for the problem drinker, 10 mg. t.i.d.; for the frank alcoholic, 25 mg. b.i.d.).
6. Injectable form available for acute episodes.



a program for early recognition and successful treatment:

Alcoholism in New Jersey*

State Rank	
total no. alcoholics	7th
no. per capita	10th
per capita consumption†	11th

New Jersey Physicians' Report
(compared with U.S. average)

	%N.J.	%U.S.
see 5 or more problem drinkers in 2-month period	34.7	37.1
half or more seen are women	41.8	37.4
treat, rather than refer	73.1	72.6
more community services needed	65.0	63.0

*based on preliminary data supplied by Center of Alcahal Studies, Rutgers Univ. †absolute alcahal

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory,** a nationwide survey of treatment centers.

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See next page for prescribing information.

INDICATIONS: In clinical studies, Serentil (mesoridozine) has been found useful in the following disease states:

Alcoholism—Acute and Chronic: Serentil ameliorates anxiety, tension, depression, nausea ond vomiting in both acute and chronic alcoholics without producing hepatic dysfunction or hindering the functional recovery of the impaired liver.

Schizophrenia: Serentil is effective in the treatment of schizophrenia. It substantially reduces the severity of Emotional Withdrawal, Conceptual Disorganization, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychoneurotic Manifestations: Serentil reduces the symptoms of anxiety ond tension, prevalent symptoms often associated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of oge is not recommended, because safe conditions for its use have not been estoblished.

Attention should be paid to the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., onesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related to Serentil, one should be aware that such changes hove been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administrotion for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection.

Leukopenia and/or agronulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of a few



(rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found among those patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remarkably low Incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos) have been reported.

Autonomic Nervous System: Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiovascular System: Hypotension and tachycardia have been reported. EKG changes have occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the following have occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autonomic Reactions: Miosis, obstipation, anorexia, paralytic Ileus.

Cutaneous Reactions: Erythema, exfoliative dermatitis, contact dermatitis.

Blood Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edema, asthma.

Hepatotoxicity: Jaundice, biliary stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed in some patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarization and not related to myocardial damage. They appear to be reversible. There is no evidence at present that these change are in any way precursors of any significant di turbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arre has been noted.

Extrapyramidal Symptoms: Akathisia, agitatio motor restlessness, dystonic reactions, trismu torticollis, opisthotonos, oculogyric crises, tremo muscular rigidity, akinesia—some of which o rare occasions have persisted for several month or years especially in patients of advanced ag with brain damage.

Endocrine Disturbances: Menstrual irregularitie altered libido, gynecomastia, weight gain. Fals positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects sugge tive of a paradoxical reaction have been reporte These include excitement, bizarre dreams, aggr vation of psychoses and toxic confusional state More recently, a peculiar skin-eye syndrome ha been recognized as a side effect following lon term treatment with phenothiazines. This reactio is marked by progressive pigmentation of area of the skin or conjunctiva and/or accompanied b discoloration of the exposed sclera and corne Opacities of the anterior lens and cornea d scribed as irregular or stellate in shape hav also been reported.

DOSAGE AND ADMINISTRATION: Oral: The do age of Serentil (mesoridazine), as in most mec cations, should be adjusted to the needs of th individual. The lowest effective dosage shoul always be used. When maximum response i achieved, dosage may be reduced gradually t a maintenance level.

Alcoholism: For most patients the usual startin dose is 25 mg. b.i.d. The usual optimum tot daily dose range is 50-200 mg. per day.

Schizophrenia: For most patients, regardless o severity, a starting dose of 50 mg. t.i.d. is recor mended. The usual optimum total daily dose rang is 100-400 mg. per day.

Behavioral Problems in Mental Deficiency an Chronic Brain Syndrome: For most patients a star ing dose of 25 mg. t.i.d. is recommended. Th usual optimum total daily dose range is 75-300 m per day.

Psychoneurotic Manifestations: For most patients th usual starting dose is 10 mg. t.i.d. The usual op mum total daily dose range Is 30-150 mg. per da

Injectable Form: In those situations in which a Intramuscular form of medicatian Is indicate Serentil (mesoridazine) Injectable Is available. Fo most patients a starting dose of 25 mg. is recor mended. The dose may be repeated In 30 to 6 minutes, if necessary. The usual optimum total dail dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 mg and 100 mg. mesoridazine (as the besylate). Bo tles of 100.

Ampuls: 1 cc. [25 mg. mesoridazine (as the besy ate)]. Inactive Ingredients—Disodium Edetat U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 mg. Carbon Dioxide Gas (Bone Dry), q.s.; Water fo Injection, U.S.P., q.s. to 1 cc. Boxes of 20 and 10

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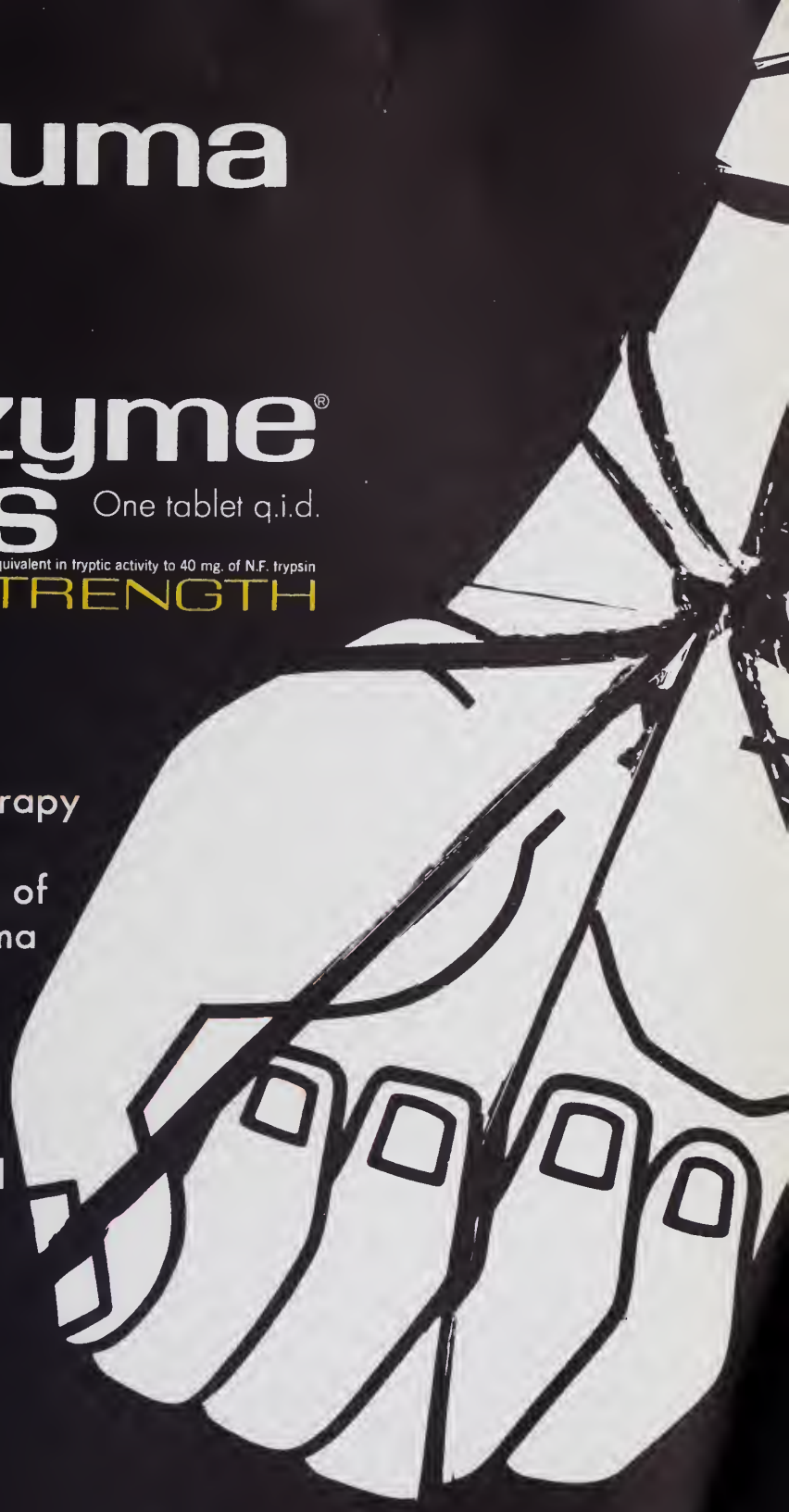
in trauma

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One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.

A FULL DAY'S DOSAGE

Description: ORENZYME BITABS affers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resalution af inflammatian and edema. ORENZYME BITABS is convenient to use, promotes patient caaperation and is ideally suited far maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolutian of inflammation and edema, good results have been obtained in:

- ☐ Accidental Trauma
- ☐ Postoperative Tissue Reactions.

Other conventional measures af treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Controindicotions: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

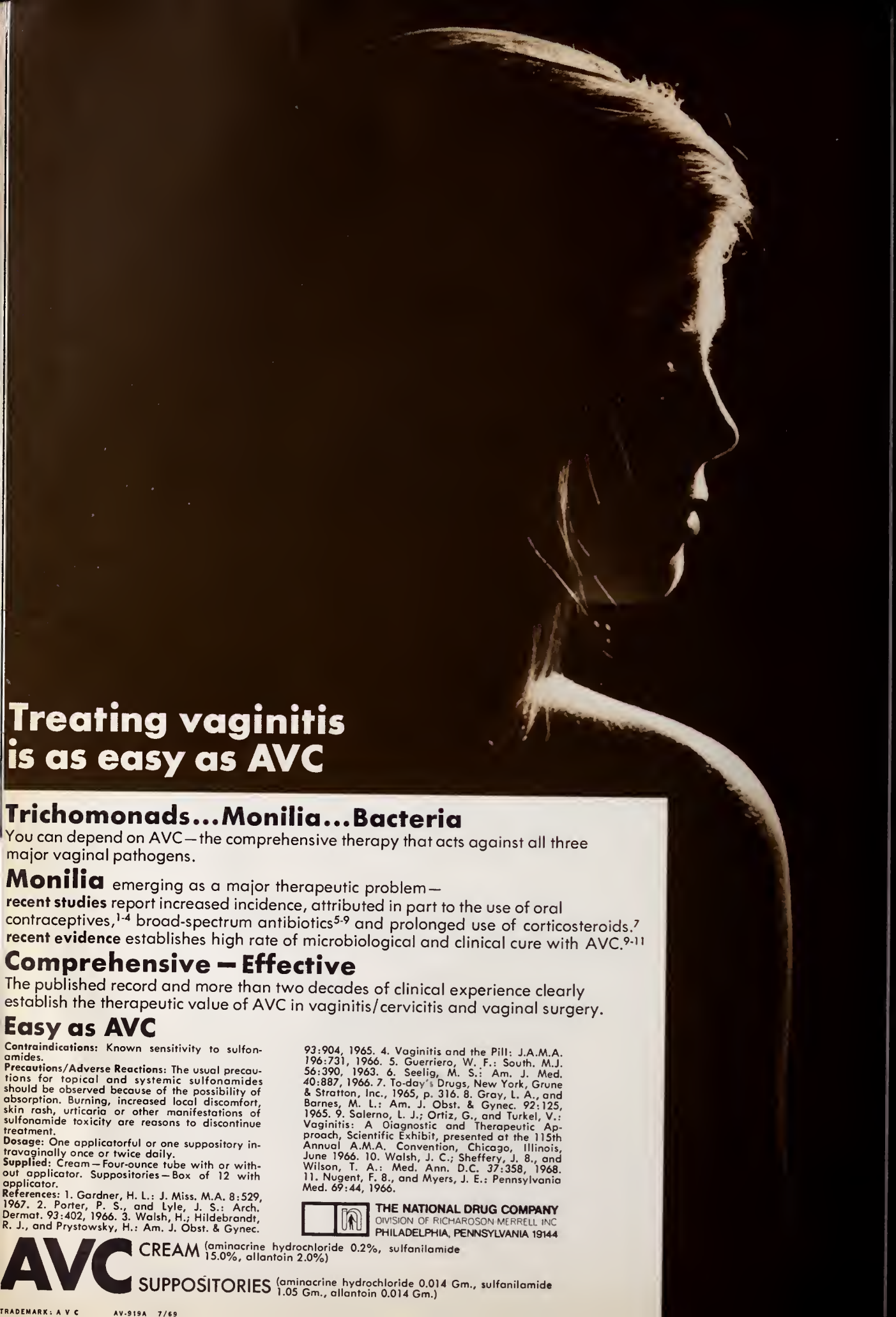
Precoutions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed af dissalution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reparted but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

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TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4/69 0-821A



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Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
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Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. 8., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. 8., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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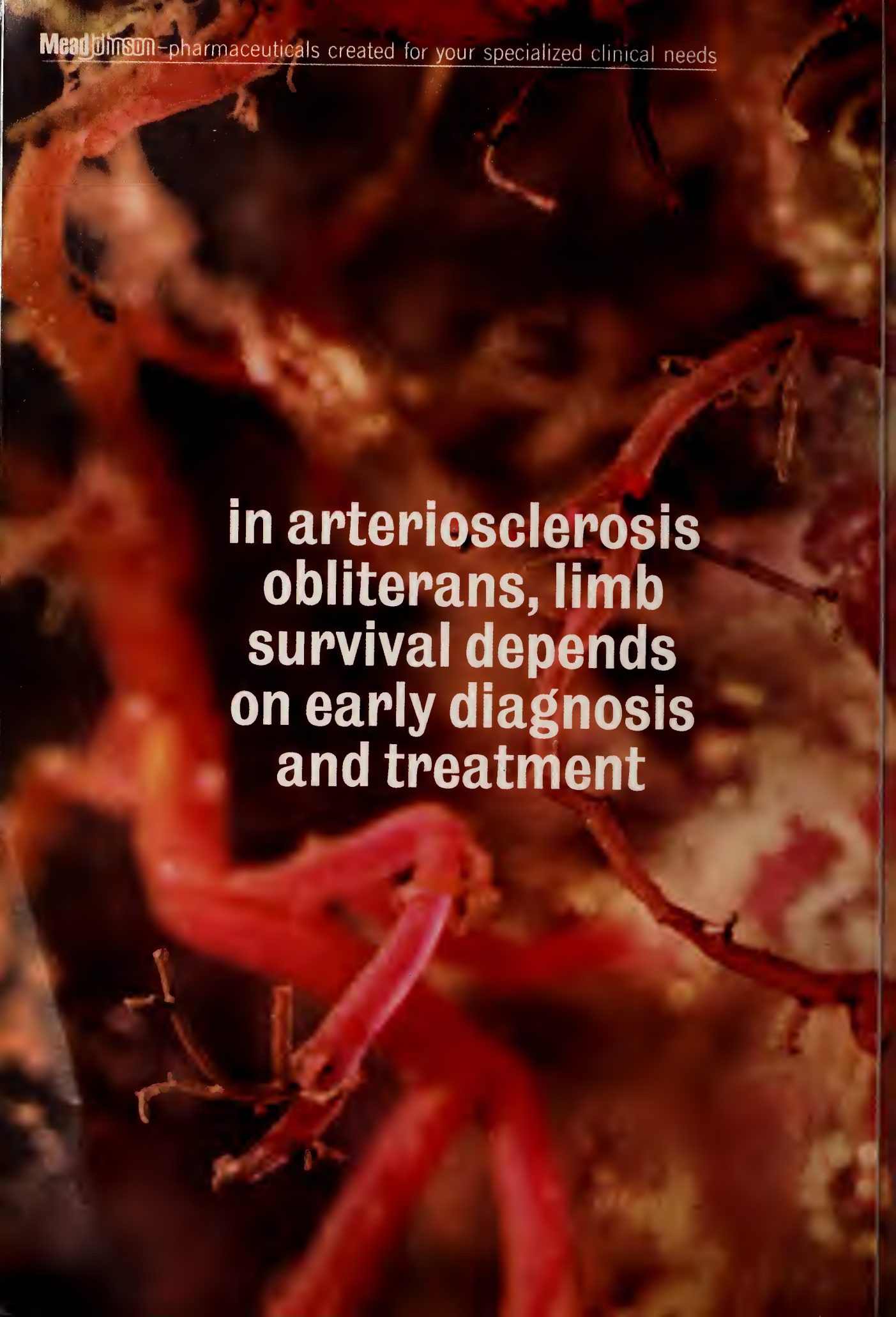
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in arteriosclerosis obliterans, limb survival depends on early diagnosis and treatment

Microphoto of small artery occlusions in a toe amputated because of severe arteriosclerosis obliterans. Cast was made by injecting acrylic plastic into the vessels. The occluded vessels measure about 30 to 50 microns in diameter. *Used with permission. Courtesy of Margaret C. Conrad, Ph.D., Department of Physiology, Bowman-Gray School of Medicine, Wake Forest College, Winston-Salem, N. C.*

in responsive arteriosclerosis obliterans

VASODILAN®

(ISOXSUPRINE HCl)

- **acts directly to increase blood flow to deep muscle arteries**[1-3]
- **improves walking ability, relieves rest pain**[3-5]
- **may be used safely in patients with peptic ulcer, diabetes or chronic coronary artery disease**[3,6,7]

New 20 mg. strength now available: Vasodilan 20 mg. tablets for greater dosage simplicity and convenience. Recommended *Initial* dose: one 20 mg. tablet q.i.d.

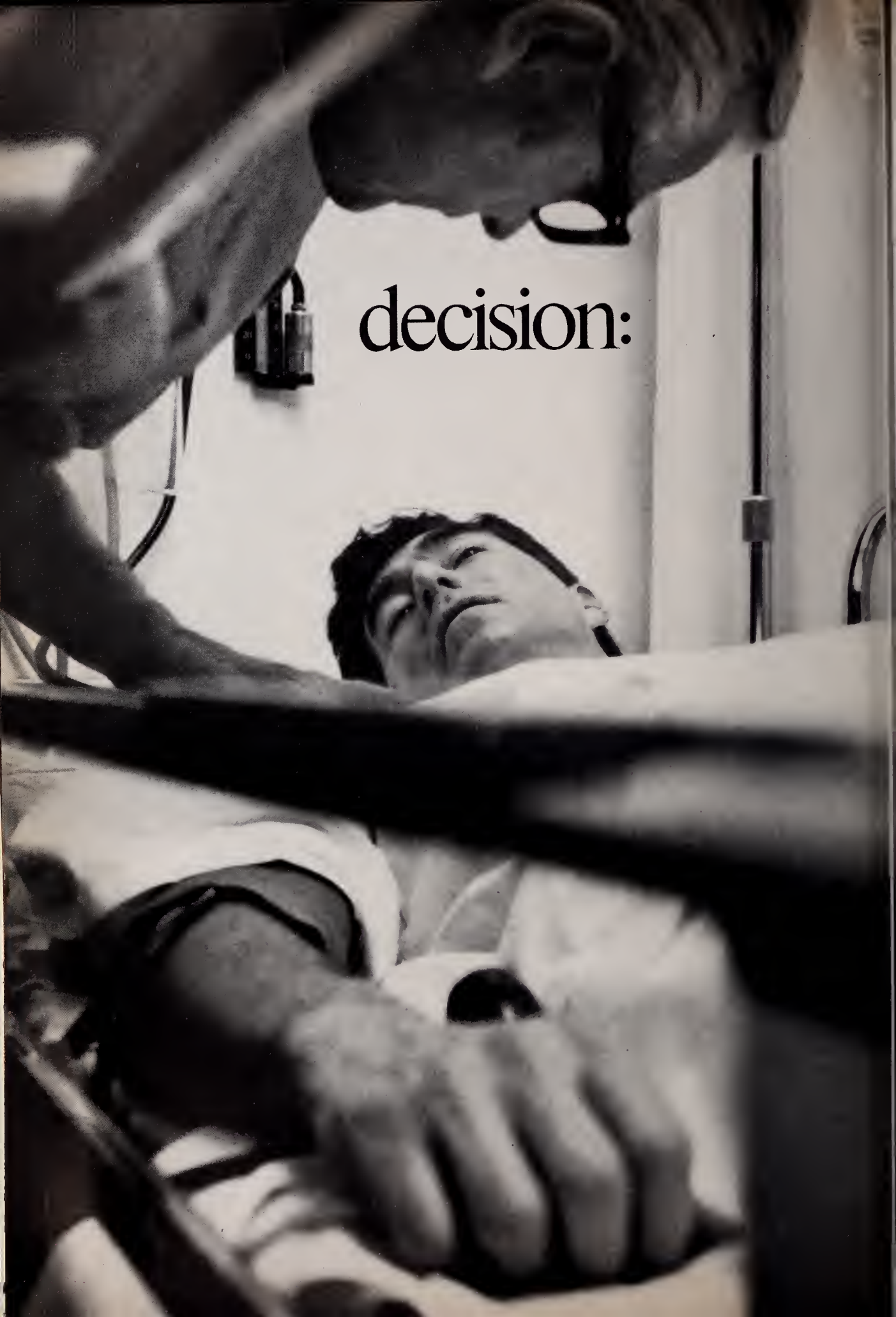
Although not all clinicians agree on the value of peripheral vasodilators,[8-10] several investigators[3,6] have reported favorably on the effects of isoxsuprine on peripheral blood flow in skeletal muscle vessels. Effects have been demonstrated both by objective measurement[1,6,11] and observation of clinical improvement.[3-5,12]

Indications: Arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODILAN tablets, isoxsuprine hydrochloride 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories.

References: (1) Stein, I. D.: Angiology *15*:1 (April) 1964. (2) New Drugs— Evaluated by the A.M.A. Council on Drugs, Chicago, American Medical Association, 1967, pp. 295-297. (3) Kaindl, F.; Pärtan, J., and Polsterer, P.: Wien. klin. Wchnschr. *68*:186-191 (March 16) 1956. (4) Frieh, Ch., and Olivier, L.: Lyon Méd. *91*:891-896 (May 24) 1959. (5) Weghaupt, Von K.: Wien. klin. Wchnschr. 69:31-32 (Jan. 11) 1957. (6) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: Angiology *10*:185-192 (Aug.) 1959. (7) Samuels, S. S., and Shaftel, H. E.: J. Indiana M. A. *54*:1021-1023 (July) 1961. (8) Myers, K. A.: Mod. Treat. *4*:370-383 (March) 1967. (9) Gillespie, J. A.: Angiology *17*:280-288 (May) 1966. (10) Smit, Arne, F., *et al.*: Nord. med. *20*:1260, 1959. (11) Samuels, S. S., and Shaftel, H. E.: J.A.M.A. *171*:142-145 (Sept. 12) 1959. (12) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960.

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  urinary tract infections
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- relatively painless I.M. injection
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*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

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CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

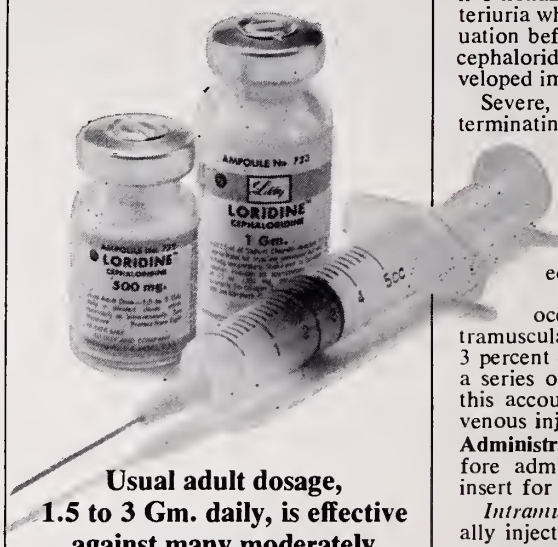
Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Loridine®
CEPHALORIDINE



Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

Additional information available upon request.

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EDITORIALS

The Challenge Of Medical Education

Never before in our State's history have we so concretely had to come to grips with the problem of medical education. Our Medical Society is on record as favoring an enlargement and expansion of medical facilities in our State. (Transactions, 1970 House of Delegates, pages 435). With sky-rocketing taxes there is concern about the cost of constructing and operating a university hospital. Dr. Harry Brodkin in our June JOURNAL published a letter in which he suggested, for the time being, use of the existing Martland Division as the clinical facility for the NJCMD in Newark. By retaining the pre-clinical program at New Brunswick, the community hospitals there would be adequate for the relatively small amount of clinical exposure needed in the first two years. Indeed, the Newark school could be enlarged to the point of providing by transfer for every student who had completed two medical school years in New Brunswick.

Our past-president, Dr. Henry B. Decker, has called attention to a proposal in the May 1970 Burlington County *News-Letter.* (See page 506 this issue) Here Dr. Colburn points out that the undergraduate college course could be restructured to provide, in effect, teaching of anatomy, physiology, histology, microbiology, and pathology. Instead of putting B.A. or B.S. on the sheepskin, this could lead to a Bachelor of Medical Science degree. At the cross-road, the student could elect either to go on to a clinical training and become an M.D. or to continue work in basic sciences and become a D.Sc. or Ph.D. The present medical school curriculum would then be completed after two years of medical school, and the internship year could be built into the medical school, perhaps withholding the M.D. degree until that is accomplished. This would assure a well-supervised internship year with that service construed as part of education instead of as a method whereby the hospital could exploit cheap labor. Furthermore, the hospitals of the community (not a research oriented "university hospital") could be used as clinical placement facilities, so that elaborate new buildings would not be needed. This would be a shot in the arm to the community hospitals, make intelligent use of our State's private medical manpower, and provide for teaching the *art* of medicine the only way it can be taught—by a supervised apprenticeship system.

A final answer is *not* just around the corner, but at least we are thinking about it, weighing the possibilities and comparing the various proposals. Come what may, medical education in our State is finally on the march—and the need now is for a bold, imaginative, and well-planned approach.

Throw Physic To The Dogs

"What rhubarb, senna, or what purgative will scour the English hence?" So asked Macbeth (V.3), reflecting the high standing of laxatives in Shakespeare's time.

Rhubarb, senna, and all others! Today's medical student is told that constipation is chiefly a matter of mind under matter, and should be treated by relaxation and psychotherapy. But a generation ago, a proper medical student had to recite the long list of laxatives from aloes to zingiber. He could tell you the dose, the place of action, the color, size, shape, and sometimes even the contra-indications. And what a roll call it was! There were the salts: Epsom, Rochelle, and Glaubers. There were psyllium and podophyllium, agar and jalap, gamboge and rhubarb, petrolatum and then the three oils: mineral, castor, and croton. He remembered cascara, calomel, colocynth, and phenophthalein too.

Take calomel. The word itself means "beautiful black." William Gilbert had Bunthorne, the fleshly poet in *Patience* say: "How can he paint her woes, knowing as well as he knows, that all can be set right with calomel?"

Keep your powder dry and your bowels open was the advice of the primitive military surgeon of the 18th century. But laxatives go back further than that. The aloe was known to Aristotle; and to the Arabs it was so precious that it was long a Government monopoly. Hippocrates recommended cabbage as a mild laxative, castor oil as a drastic one. Magnesium sulfate made the village of Epsom famous and Queen Anne and King Charles II drank of its saline waters. Trips to Epsom attained the immortality of mention in the *Diary of Samuel Pepys.*

The medicine of those days seems so simple now—no worry about liver function, antibiotics, or vitamins. No one then ever heard of electrolytic imbalance. Disease seemed to come from noxious things within, and the doctor had to remove the animalcules by purging, puking, or bleeding. The big black bag included the famous British "black draught" (a senna preparation) or maybe—if the doctor had made the grand tour of the continent—a bottle of *Wiener Trank* (another senna preparation). The world *physic* was used indifferently for medicine in general and for laxatives in particular.

But now this bit of medical learning has decayed. The detail man can tell you of a laxative that neither binds nor gripes. It is firm but gentle. It strikes the patient at the most convenient time and leaves him relaxed, refreshed, and relieved. It may be a bit expensive, but the patient gets a fair run for his money. It is easy to prescribe—just a scrawl on a prescription blank. No need for the doctor to learn the difference between purgatives, salines, aperients, and hydragogues. That is all gone with the wind, so to speak.

So the modern medical student agrees with Macbeth. "Throw physic to the dogs" he says.

Comes The Post-Industrial Revolution

You may call a computer an "electronic brain" but there is one thing a human brain can do that a data processing machine can't. That is, innovate. The computer can do only what it is programed to do, and it takes a human being to handle the program input. Theoretically, we should be able to put together machines that will do housework chores just as we have developed machines that can dig ditches. Already there are data processing devices into which you can feed a patient's symptoms and come up with a list of diagnostic possibilities. Just around the corner are machines that will compare the effectiveness of various treatment regimes for one set of symptoms with the effect on patients with another set of symptoms.

If this trend continues, there will be more and more demand for smarter, or at least better educated people to handle the programing. And if enough of these are developed, the working week can be sharply reduced. The rewards of "work" will be prestige, a sense of accomplishment, and the sheer enjoyment of the work itself. A society capable of developing such machinery (and capable of landing men on the moon) will be capable of abolishing poverty, so that money will not be the goal of work. When that time comes, and people work for accomplishment, a sense of usefulness, a feeling of joy on the job and a sense of having made a contribution — when people can all do that, and not work just to make money, then, would you believe, we will catch up to our adolescent children and grand-children. Because that is the burden of their grievance against our generation. We're too much concerned about material things, they say, and not about these spiritual values. So give us time, and we'll achieve their standards — as soon as we perfect the data processor and the robot workman. An intellectual has been defined as a person who finds his work a kind of play. And comes this post-industrial revolution we can all be intellectuals.

ORIGINAL ARTICLES

We do have a role in what Dr. Wolfson calls "recreational pharmacology." This paper offers practical counsel on handling the acutely toxic user.

Drug Abuse: The Doctor's Role*

Edward A. Wolfson, M.D./Newark

Physicians are finding themselves increasingly involved in the modern epidemic of drug abuse. Understandably, the doctors' participation in the drug scene may not coincide, in many instances, with their personal viewpoint or preference. However, patients are coming to emergency rooms and private offices in the midst of a bad "trip" with distressing frequency. They need our help! Yet we are in a vulnerable and sometimes difficult position. Our society has become a nation of pill-taking, needle-happy hypochondriacs, who too frequently have turned to chemicals to aid sleep, pills for pep, drugs to gain and lose weight, and the all-time favorite aids to assure bowel regularity. The pharmaceutical revolution has been of extraordinary help in the prevention, diagnosis, and treatment of human disease. An unfortunate side-effect (another example of iatrogenic disease) has been the development of a philosophy that all of our problems can be handled by drugs. The general public and mass media accuse the medical profession of having helped to create these attitudes by the sometimes indiscriminate prescribing of drugs, resulting in legions of "legal drug abusers."

In addition, our culture has accepted the idea of *recreational pharmacology;* we approve of some drugs, not only to cure disease or to ease pain or other symptoms, but merely because in certain situations the drug effect is pleasurable. The before-lunch, after-work, cocktail party staple alcohol is a prime example of the philosophy of "recreation or pleasure through chemistry." In a sense, viewed in the light of society's acceptance of the principles of recreational pharmacology and the self-prescribing of drugs, the "alienated" youth turning to drugs is not necessarily exhibiting deviant behavior nor a revolt against an older generation.

Most physicians have never had any formal education or training in the field of drug abuse. We claim no special philosophical or sociologic talent or expertise which is necessary to cope with this multi-faceted and complex subject. Indeed few medical problems are so inundated with ignorance, lack of hard facts, poverty of scientific methodology, and with personal biases, hang-ups, and ideologies. Most medical schools have not taught drug abuse, but rather have emphasized classical clinical pharmacology, the biochemical and physiologic effects of drugs on tissues and organ systems.

It is true for drugs in general, but more so with drugs that are abused (and especially true of the psychedelics) that the effects are an interaction between basic pharmacological properties, including dosages and the route of administration, the personality of the drug user, the setting in which the drug is taken, the reasons why the drug was taken, the expectations of the user, and the user's ability to recognize the effects. Observed and described reactions vary considerably from individual to individual, and in the same individual from exposure to exposure.

Physicians must be aware that a good "trip"

* Read before the Special Session on Drug Abuse, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1970. Dr. Wolfson is Associate Professor of Public Health and Preventive Medicine, and the Director of the Division of Drug Abuse at the New Jersey College of Medicine and Dentistry.

can rapidly turn sour by a mere threatening gesture or reprimand. Conversely, a sympathetic and understanding approach may enable the doctor to manipulate a bad drug experience into one that the patient may handle without prescribed medication. This "talking down a trip" approach may diminish long-term psychological damage and the frequency of "flash-backs" (recurrent trips) and also allow the physician to gain the trust of the patient for future counseling or referral for help at the appropriate time.

Let us agree, at least, on our terminology. The mass media constantly refer to "dope" and "marijuana addiction." Headlines scream "narcotic arrests" when some youngsters are caught with one or two "joints" of marijuana. It is imperative that at least the physicians know the ground rules in order to keep the game in its proper perspective. This is a plea for accuracy in terminology and understanding of basic definitions.

The most acceptable working definition of a *drug* is any substance that has any physiologic or psychologic effect—indeed, anything that alters the structure or function of living tissue. Any sensible classification of drugs should follow along pharmacological or clinical lines. Laws relating to drugs should be consistent with the pharmacology of the compound they are designed to control.

In a broad sense, *drug abuse* is the self-administration of a drug in a manner that deviates from approved or social patterns. In reality, this may include any drug, but we are here relating to the abuse of drugs taken to produce changes in mood and behavior, and which are obtained illicitly (not forgetting the other major problem of legal drug abuse). Implicit in this concept is that society's acceptance of various drugs changes from time to time and from culture to culture; i.e., accepted practice of opium smoking in China until quite recently.

Drug abuse may lead to *compulsive abuse* when the user feels that the effects of the drug are necessary to maintain an optimal state of well-being. Here there is a spectrum of preoccupation varying from desire to craving to compulsion. An accepted synonym is *psychological dependence,* sometimes referred to as *habituation.*

A serious problem is tolerance, whereby an increasing amount of the drug becomes necessary to obtain the same effect. This becomes especially dangerous when dealing with narcotics, amphetamines, and the sedative-hypnotic group of abused drugs (such as barbiturates and alcohol). Not all of the effects of a particular drug necessarily exhibit tolerance at the same rate, an example being the continued insomnia in the amphetamine user, regardless of dosage. Often associated with, but somewhat different from tolerance, is *physical dependence,* a state whereby the drug is necessary to prevent withdrawal or an abstinence syndrome. Abstinence syndromes, or reaction phases, vary depending upon the particular drug dependency. When a heroin addict is intoxicated, he is sedated or "on the nod." In withdrawal, however, the reaction phase of excitation predominates. The intoxicated amphetamine user is agitated and hyperexcitable. In withdrawal, a state of depression and exhaustion exists, the individual often lapsing into a deep sleep for long periods. It is probable that physical dependence (and possibly tolerance) occurs at least to some degree with a single dose of an opiate or barbiturate. This may result in a slight exacerbation of the underlying anxieties for which the drug may have been used initially and/or a beginning of withdrawal or reaction phase. The cycle of chronic and repetitive use may thus have been triggered in the susceptible. The word *addiction* connotes compulsive and overwhelming involvement with the use of and the obtaining of a supply of a drug usually having the properties of physical and psychological dependence. Physical dependence may be present without "addiction" used in this generally accepted sense, as evidenced by the neonate born to a heroin addict; clearly, there is no psychological involvement, and the infant is not habituated.

Acute Drug Reaction

The medical training and expertise of the physician should be most evident in actual confrontation with the patient in the acute stage—the patient in a coma, possibly delirious, often profoundly depressed, euphoric or beyond, occasionally violent, or possibly fearful. It is not within the scope of this presentation to describe the pharmacology of the drugs of abuse in detail; the reader should refer to the standard texts and to the many excellent articles in the recent literature. Let us, however, here present points of interest and interpretation, which may clarify the subject and make the physician more comfortable in the doctor-drug abuse patient relationship. The major problem (a sometimes not inconsiderable hurdle) is to discover what drug has been taken, how much, and when. Clearly, the conscious patient or his accompanying friends are the best source of information, but they may be reluctant, uncommunicative, grandiose, unknowing, or antagonistic.

Exact information may be impossible to obtain, and it is safer to assume you do not know the particular drug. With increasing frequency, drug users are sold pills which are not what they are purported to be. They may contain a high proportion of adulterants, such as strychnine, to put a little "kick" in it. They may be of poor quality and possibly inactive, or may be one of the widely used combinations, i.e., the "peace pill," a mixture of LSD, cocaine, and mescaline.

The major principle in the acute treatment of drug abuse is to treat the reaction, the physiologic variations from homeostasis, rather than the drug *per se*. In general, the entire spectrum fits into four major categories: narcotics, central nervous system stimulants, psychedelics, and the sedative-hypnotic group.

Narcotics

This group (opiates derived from the opium poppy or chemically related equivalents or derivatives) is best characterized as effective analgesics (actually there is an altered reaction to pain, since the pain *per se* may be perceived), and profound central nervous system depressants. The frequently described euphoria may be due to the relief from pain, worry, tension, and anxiety in those with low thresholds. Most of the effects of opiate addiction (excluding so-called overdose and respiratory depression) are not related to the drug action *per se*. Most complications or untoward medical effects are related to the manner in which the illicit drug is used and the life the addict lives. This includes serum hepatitis, skin infections, septicemia, endocarditis, anemia, weight loss, tetanus, and dental caries.

Recognition of the chronic narcotic addict with his pin-point pupils (or inappropriate use of sun glasses to hide the pupils) and scars or pigmentation over the veins (frequently there is tattooing to obliterate the tell-tale marks) is usually not difficult. The major medical problems due to the action of the opiates are related to the overdosage phenomenon and to abstinence symptoms. Non-fatal overdose will be seen in the emergency rooms and should be diagnosed promptly in the suspected user, if diffuse pulmonary infiltrates are accompanied by stupor, small pupils, and either a normal or slowed breathing rate. Basically we are dealing with profound central nervous system depression, including respiratory center depression, leading to the paradox of pulmonary edema without the usual tachypnea. Since the effects are reversible, prompt supportive treatment, including positive pressure oxygen and maintenance of the blood pressure, may be lifesaving. Usually diuretics, digitalis, and rotating tourniquets are not necessary. Careful use of Nalline® (nalorphine) or Lorfan® (levallorphan tartrate) in intravenous doses of three to ten milligrams; or one milligram, respectively is dramatic in its increase of respirations (and concomitant dilitation of pupils which, in a sense, is a diagnostic test). Two points deserve emphasis: (1) Large doses may precipitate a profound abstinence syndrome;

(2) The narcotic antagonists are metabolized rapidly and may have to be repeated two to three times at 15 to 30-minute intervals to avoid the return of the respiratory depression due to the longer acting opiate.

The intensity of withdrawal increases with the degree of physical dependence, symptoms usually starting 8 to 12 hours after the last "fix" and peaking at 36 to 72 hours. Symptoms include any or all of the following: nervousness; anxiety; sleeplessness; yawning; lacrimation; diaphoresis; piloerection; muscle cramps and twitching; vomiting and diarrhea; tachypnea and tachycardia. Administering methadone for three to five days eases withdrawal symptoms, and there is no contraindication to the use of sedatives. In a recent study, diazepam (Valium®) was used, and the results to date compare favorably with methadone in controlling abstinence symptoms.

Central Nervous System Stimulants

Amphetamines (the major representative of this category) are becoming a major health hazard due to the rapid increase in their use and the drugs' inherent biologic dangers. Amphetamines are powerful central nervous system stimulants with considerable sympathomimetic properties. In moderate dosages, an increase in work performance, alertness, diminished fatigue, restlessness, agitation, sleeplessness, and loss of appetite are usually observed. Therapeutically, the amphetamines have been used as appetite suppressants, have been used in cases of central nervous system depressant intoxication, in depressive syndromes, and in narcolepsy. Except for narcolepsy, amphetamines are not considered the drug of choice. Their use is now being questioned because of the abuse potential, availability of other more effective agents, and because of the rapid onset of tolerance. (Interestingly, tolerance does not seem to manifest itself when the amphetamines are used in narcolepsy.) In the past, amphetamines were sometimes used to "wake up" overdosed heroin users; this often resulted in the substitution of one drug of abuse for another, and heroin addicts often became stimulant habitues.

With chronic and increasing use, the following adverse effects often occur: irritability; insomnia; aggression; bizarre and sometimes inappropriate repetitive actions; and, eventually, panic, confusion, and paranoid psychosis. Other medical problems include effects related to unsterile intravenous usage, as noted with heroin addiction, and to exaggerated sympathomimetic activity resulting in tachycardia, arrhythmias, and profound hypertension.

In the "low dosage" oral cycle, the use of the stimulant to augment energy and produce euphoria is often intermittently counteracted by the use of barbiturates to allay agitation and insomnia—the "yo-yo" phenomenon or the "ups and downs" syndrome. More destructive is the high-dose methamphetamine ("Speed") cycle in which the addict mainlines in order to achieve a rapid reaction, a "flash" or "rush," described as a "full body orgasm." The flash is transient, and the "speed freak" may mainline every hour or so, since an overwhelming compulsion for and involvement with the drug is often noted. The "active phase" or "speed binge" may last for many days with the user in a continuous state of hyperexcitement without sleep or food. Finally, whether due to exhaustion and fatigue, frightening emotional disturbances, or inability to obtain the drug, the binge is terminated, resulting in the "crash," the reaction phase of exhaustion, sleep, and depression. In some areas, young persons are told that heroin eases the crash, and the increasing use of heroin in the schools and suburbs may in part be reflecting and paralleling the "speed" epidemic. In addition, "speed" is now being used frequently together with heroin to achieve the "orgasm" and potentiate the opiate euphoria, the so-called "bombita," substituting for the older cocaine-heroin combination, colloquially known as the "speedball." "Speed" indeed may "kill!"

Apparently, many "speed" users do not re-

turn to a baseline of personality function after the crash and have a prolonged sub-acute phase of profound depression—unfortunately managed by the "speed freak" by starting another cycle. The most acceptable medical treatment of amphetamine intoxication (including convulsions, delirium, combativeness, the head-banging, mutilation of digits, and biting noted in youngsters, and excessive sympathomimetic symptoms) is the use of chlorpromazine. This is sometimes successful after failure to observe a significant response to barbiturates. Because combinations of amphetamines and barbiturates are used frequently, the therapeutic use of the barbiturates may exaggerate sub-clinical depressant effects. Chlorpromazine can reverse hyperthermia and electro-encephalographic changes which the barbiturates sometimes accomplish only in anesthetic dosages. Support of circulation, seizure precautions, maintenance of airway, avoidance of stimulation, and the use of alpha-adrenergic blocking agents (i.e., Dibenzyline®), when appropriate for profound hypertension, must be considered concomitantly.

Psychedelics

Because of its potency and widespread availability, LSD is by far the most important hallucinogen. Although experiencing a greater notoriety and popularity, marijuana is a relatively minor league drug which only rarely presents itself as an acute medical problem. The physician's contact with "grass" would ordinarily be as a counselor or adviser to the chronic user, the "pothead" experiencing the "loss of motivation" syndrome.

LSD does not lead to physical dependence. We do not deal with "LSD addicts." The effects are almost entirely on the higher central nervous system centers, apparently resulting in a bombardment of sensory stimuli, without the usual effective filtering out selectivity or normal barriers to perception. The user of "acid" experiences perceptual, spatial, and temporal distortions, changes in body image, and occasionally synesthesia, the translating of one type of sensory experience into another ("hears" color; "sees" sounds). During a bad "trip," there may be acute distress, fear, hallucinations, emotional lability, feelings of panic and persecution, and attempts to act out feeling states, resulting in unintentional suicide attempts (sometimes successful).

The effects of LSD on chromosomal aberrations are debatable, and while we caution against causal inference, there is some evidence that there are a significant number of chromosomal breaks and re-combinations associated with the use of LSD.

The plethora of psychedelics available on the street—STP, mescaline, DMT, *et al.* means that they can be taken knowingly or unknowingly. While the phenothiazines are an accepted therapy for LSD agitation, a case of potentiating central nervous system depression has been recorded when they were used during the excitement phase (release of inhibition) of a trip on PCP, a veterinary anesthetic (phenylcyclohexylpiperidine), which was sold on the street as THC (tetrahydrocannabinol), the presumed active principal of cannabis. Similarly, chlorpromazine seems to potentiate the effects of STP (Serenity, Tranquility, and Peace), a methoxy methyl amphetamine, possibly due to the presence of belladonna-like adulterants in the STP. It is likely that diazepam (tradenamed Valium®) does not potentiate the effects of the commonly abused drugs, and therefore should be the drug of choice in the emergency treatment of acute drug intoxications.

If the airway is open, breathing normal, and cardiovascular status intact, is *any* treatment necessary in what will almost always be a self-limited emotional reaction? If the patient has taken a combination of drugs, adding additional agents to the burden may be injurious, a patient experiencing an LSD hallucination after ingesting an LSD-barbiturate combination pill will not do well with the increasing sedation action of the phenothiazines. The maintenance of a non-threatening environment is far more effective medicine,

but it takes considerably more time. Not giving "antidotes" creates medical anxieties. The only specific antidotes are the narcotic antagonists for heroin respiratory depression, and among other symptoms, only convulsions (regardless of etiology) require prompt chemical intervention.

Sedative-Hypnotic Group

The model is the barbiturate, the "downs" or "goofballs," but the group includes, among others, glutethimide (Doriden®) and alcohol. Each has a potential for abuse, and chronic use results in tolerance and psychologic and physiologic dependence. In combination, these agents may act synergistically and each, especially on withdrawal, can cause convulsions, coma, and death. The generally used tranquilizers; i.e., chlordiazepoxide and diazepam, usually produce minimal psychological dependence (and thus have a "low abuse" potential). There is no clear cut tolerance with these agents.

Barbiturates are general central nervous system depressants with a spectrum of effects from mild sedation to sleep to anesthesia and coma. The therapeutically important anticonvulsant effect seems not to be related solely to sedation, since amphetamines counteract sedation without abolishing the anticonvulsant activity. The initial feeling of tranquility, elation, and well-being soon gives way in the chronic, excessive user to irritability, impairment of mental ability, motor incoordination, confusion, lack of concern, time distortion, inappropriate mood shifts, and general emotional instability. In essence, we observe the inebriated alcoholic without the odor of ethanol! The barbiturate addict experiences life with the edge of anxiety dulled, and there is a decreased inhibition of drive, with resultant exaggeration of basic conflicts. This differs from the opiate addict, where usually there is a total satiation of drives. Of interest, children and the elderly often experience excitement rather quickly on barbiturates.

Despite tolerance, the central nervous system lethal dose does not differ greatly from the non-addict. The innocent cocktail party thus may be lethal for the barbiturate addict. Withdrawal from barbiturate addiction is serious, often deadly. It is more difficult to handle than heroin withdrawal and should be treated only in a general hospital setting. The withdrawal mimics the delirium tremens of alcohol, and similar paroxysmal electroencephalographic abnormalities are noted; this is really a "general depressant withdrawal" syndrome.

Symptoms of withdrawal, resembling intoxication and starting in about twelve hours, include restlessness, anxiety, fine tremors, abdominal cramps, nausea and vomiting, and orthostatic hypotension. After 24 hours, coarse tremors and hyperactive reflexes are noted, and the addict pleads for the drug. Actually, withdrawal should be a slow and tapered process, literally lasting several weeks.

A frequent danger is that the patient may be sent home from the emergency room after quieting down with a sedative, all concerned having a false sense of security. It is only during the second to third day that delirium and convulsions start with progression over the ensuing three to four days to paranoid delusions, hyperthermia, and vascular collapse, if untreated with gradual tapering of the drug and general supportive therapy.

A general word of caution. A case was described in *The Journal of the American Medical Association* (December, 1969), where an unkempt youngster with long hair and bizarre behavior was brought to the emergency room by his "hippie" friends and was treated initially for what was "obviously" a bad drug trip. The true diagnosis of meningitis was delayed, probably a failure on the part of the examining physicians to separate long hair and odd clothing from odd behavior, as a symptom of disease.

The Doctor's Role

Physicians are increasingly involved with the modern epidemic of drug abuse. The medical school curriculum must include formal train-

ing in the subject, so that future physicians will be more expert and feel more comfortable with this perplexing problem that transcends the limitations of many professional disciplines.

Physicians must exercise their traditional leadership and become totally committed to approaching drug abuse in a compassionate, understanding, yet scientific manner. Every county medical society should have an *active* "Drug Abuse Committee," and a "hot line" should be set up to operate around the clock. We must educate ourselves so that we may educate others and not leave the field to zealots or the biased few.

As parents, we must insist that school officials institute a comprehensive curriculum starting in the early grades, which will teach youngsters respect for, the value of, and the effects of drugs in general. We should encourage State officials to introduce meaningful and relevant courses in our State Teachers' Colleges. We must support the efforts of the specially trained to conduct in-depth courses for carefully selected teachers who have proved their ability to relate to youngsters and who are interested—these teachers in turn can serve each school as the *in situ* source of expertise, student ombudsman, and confidential counselor. A workable program of counseling and referral must be encouraged in each school system, whereby drug abusers are helped and guided rather than ignored, avoided, or turned over to the law as the first lines of action.

As physicians and scientists, we should encourage the acceptance of a confidential, medically-oriented Registry for Drug Abuse patterned after the registers for venereal disease or tuberculosis. We should consider proposals for some control over the prescribing of methadone by private physicians and the licensing of those involved in treating narcotic addicts. We must insist that all drug programs, education or rehabilitation, submit to extramural evaluation. Physicians are citizens first, and their expertise is needed in community affairs.

In a word, the physician must become involved.

If physicians do not become involved, our communities and youngsters will surely suffer an unusual type of "withdrawal syndrome" due to lack of medical guidance and expertise.

100 Bergen Street

The National Blood Resource Program

The National Blood Resource Program is a cooperative endeavor involving the National Institutes of Health and other federal and non-federal agencies concerned with the acquisition, processing, distribution, usage, or study of blood. The program surveys our nation's blood resources and their utilization. It faces a steadily accelerating demand for blood fractions. The program hopes to devise efficient, highly automated methods for the mass production of plasma and cellular fractions of blood. It expects to develop improved, high-yield technics for the large-scale fractionation of plasma to provide albumin, gamma globulin, blood clotting factors, and other protein fractions.

The program will investigate additives for prolonging the shelf-life of whole blood and cellular fractions stored under standard conditions. It will study the feasibility of a computerized daily shelf inventory system for blood to minimize losses due to outdating, or to meet local shortages, and to minimize problems arising from fluctuations in supply and demand.

A simple nine-point program for the management of premature rupture of membranes is here suggested.

Suggested Management Of Prematurely Ruptured Membranes

Bertold Salzmann, M.D./Linden

Spontaneous rupture of membranes before onset of labor has been a problem since the beginning of midwifery. Also the public looks at this portentous occurrence with great anxiety partly because of second-hand information and partly as a result of previous personal experience. Actually, most cases of premature rupture of membranes resolve themselves by spontaneous onset of labor within a few hours, both the mother and the infant being none the worse for the experience. The time element is of the greatest importance—the greater the number of hours before the onset of labor the greater potential danger of infection. Therefore, it would seem advantageous to accomplish delivery as expeditiously and in as simple a manner as possible.

Immediately one obstacle will present itself: fetuses delivered before the 36th week of gestation have a high mortality rate. Most physicians take a "hands off" policy in these cases in spite of the ruptured membranes. They may be rewarded by gaining more time for the intrauterine development of the fetus. Here again, most patients will commence spontaneous labor within a few days. However, some of these women will continue their pregnancy for several weeks longer. In the latter group we find, not infrequently bulging forewaters when labor begins. It is then assumed that amniotic fluid had been escaping through an opening situated high up in the membranes. Since infection will rarely occur in premature cases managed conservatively (without interference), this will make one wonder what the cause of this immunity might be. One may very well invoke lack of interference as explanation.

When a patient enters the hospital with prematurely ruptured membrances at forty weeks gestation (or near term), the tendency will be to accomplish delivery by induction of labor. Usually a dilute solution of Pitocin is administered intravenously to accomplish this end. In most cases, labor will commence promptly and spontaneous delivery will ensue, unless there are other obstetrical complications. Unfortunately, this happy result is not always obtained. Pitocin induction may not work. Twelve to twenty-four hours later a renewed attempt at induction is made. By this time, the patient has been subjected to frequent vaginal and/or rectal examinations and a rise in temperature may be noticed. However, contractions have not started yet, or may be mild and ineffectual. The patient is now placed on antimicrobial therapy and given sedation for rest with the view of attempting renewed induction "tomorrow morning when she will be rested." By this time infection may be obvious and urgency for evacuation of the uterus is indisputable. The fetus may have succumbed to the infection by now. But "You wouldn't do a section for a dead and infected fetus, would you?" Pitocin induction, now in higher concentration, will be tried once again and a point of no return may soon be reached: no labor, and the patient must be delivered! Now a cesarean

section will be performed by a consultant who may choose the extraperitoneal approach in an attempt to ward off severest generalized infection. Sometimes the patient will be saved, but not always. Disastrous complications may ensue, e.g. peritonitis, anuria, embolization, death.

Why do some patients not respond to Pitocin induction of labor and why do they develop infection? Of course, as it so frequently happens, the answer can be only speculative. It would seem that induction was not successful, because the cervix was not ready for induction, in the first place. Infection occurred or deteriorated, because innumerable rectal or vaginal examinations were done to ascertain the efficacy of the induction. And, possibly, all would have turned out well had there been no hesitation to terminate the pregnancy by cesarean section immediately at the onset of morbidity.

Several years ago I established for myself the following rules in managing cases of prematurely ruptured membranes:

1. The patient is admitted to the hospital and placed on strict bedrest.

2. Polarity of the fetus is established by abdominal palpation, possibly confirmed by radiography.

3. For patients who have not reached the 37th week of gestation, nothing else is done, beside recording oral temperatures every four hours.

4. Patients of more than 37 weeks' gestation are examined vaginally under sterile conditions once and *once only*. The purpose of this is to establish the condition of the cervix and to take a cervical culture.

5. If the cervix is ready for induction (as demonstrated by central position of the cervix effacement, and dilatation of at least 15 millimeters) Pitocin induction is attempted forthwith.

6. If the induction is not effective within 24 hours the pregnancy will be terminated by cesarean section, even without interceding morbidity.

7. If morbidity intervenes during Pitocin induction there will be no hesitation to terminate the pregnancy within four hours by cesarean section.

8. If, at initial vaginal examination the cervix is found to be long, not dilated, posteriorly situated, no attempt is made at induction of labor and the following policy will go into effect:

a. Strict bed rest

b. No rectal and no vaginal examinations until spontaneous and active labor is established.

c. Oral temperatures to be taken every four hours and carefully recorded.

d. If oral temperature rises above 100 it is to be reported immediately to the physician who will try Pitocin induction at once.

e. If induction is not successful within four hours pregnancy will be terminated by cesarean section regardless of whether fetus is alive.

9. If the patient's temperature is 100 or more on admission, attempt at Pitocin induction of labor will be made at once without regard to the condition of the cervix and the period of gestation, because existence of morbidity is then assumed. If unsuccessful within four hours, termination of pregnancy will be accomplished by cesarean section.

It seems to me that this is a simple and logical approach to the problem. The potential danger of premature rupture of membranes is maternal and fetal morbidity and mortality. The approach outlined here may enable the physician to recognize potential infection at its very inception and to terminate it by rational intervention. It is admitted that occasionally an unnecessary cesarean section will be performed. However, the over-all results will be better by adhering to this policy than by individualization.

46 Gesner Street

Described here is another example of how unrecognized lung cancer may manifest itself.

Hyperparathyroidism In Carcinoma Of The Bronchus

Sylvan E. Moolten, M.D./New Brunswick

The best known endocrine syndromes originating in non-endocrine tumors are hypoglycemia, Cushing's syndrome, polycythemia, hypercalcemia, precocious puberty, the atypical carcinoid syndrome, inappropriate secretion of an antidiuretic substance, and hyperthyroidism. In Cushing's syndrome and polycythemia the substances produced by such tumors have many of the physical and chemical characteristics of the normal hormones, adrenocorticotropic hormone and erythropoietin. Hypoglycemia and hyperthyroidism are probably not the result of insulin or thyroid-stimulating hormone[1] but of tumor products that incidentally possess these biologic activities.[2]

The hypothesis that certain nonparathyroid tumors associated with hypercalcemia contain a parathyroid hormone-like substance has been examined experimentally. In one study,[3] bio-assay of extracts of such tumors failed to produce clearcut elevation of serum calcium in parathyroidectomized rats. In another,[4] a carcinoma of the kidney was found by an immunologic method to contain a parathyroid hormone-like substance. In this case nephrectomy brought about reversal of the entire clinical syndrome of hypercalcemia and alkalosis.

In contrast to true hyperparathyroidism, characteristic bone changes in this syndrome are lacking. Nevertheless, as in classical hyperparathyroidism, the high serum calcium is mirrored by low serum phosphorus. The serum alkaline phosphatase is also frequently elevated. It must be recalled that true hyperparathyroidism may exist without bone or kidney manifestations.[5]

Alternative explanations for hypercalcemia in neoplastic disease include the possibility that a vitamin D-like substance is produced, or, as in sarcoidosis, that the patient is made more sensitive to the action of ordinary amounts of vitamin D in the diet. According to Plimpton and Gellhorn[6] the elevated serum alkaline phosphatase in many cases of carcinoma raises the possibility that the high serum calcium actually represents an increase in a calcium-binding material in the blood.[7] As a result, secondary hyperparathyroidism is induced with mobilization of bone salts and consequent rise in serum alkaline phosphatase. The tendency for the serum phosphorus to be low in the syndrome of hypercalcemia related to cancer is hard to explain although it is certainly compatible with the concept that these tumors produce a parathyroid-like hormone.[6]

Possibly because of the unusually high level of serum calcium, the principal clinical feature in this syndrome is profound weakness simulating myasthenia gravis. Persistent nausea and vomiting are also common. In fact, gastrointestinal disturbances may dominate the clinical picture, vomiting being the chief symptom. In certain of these cases prolonged illness characterized by weakness and weight loss may end in sudden and unexpected death. The following case is reported to emphasize the importance of early recognition of hypercalcemia as the cause of rapidly developing anorexia, weight loss, and weakness, which, in this particular case, was associated with clinically undiagnosed carcinoma of the bronchus.

A 72 year old man had been treated for many years for chronic peptic ulcer. Gastrojejunostomy was performed 30 years ago because of severe upper gastrointestinal bleeding, which recurred three years later. During the past five months, he had extremely poor appetite and had lost about 20 pounds. Three months before admission he had a passage of tarry stools This recurred three weeks later together with hematemesis He was admitted with the diagnosis of "bleeding marginal ulcer". Partial gastrectomy and gastroenterostomy were performed on an emergency basis and the old gastroenterostomy was taken down. A fairly recent sharply punched out crescentic ulceration measuring 1.6 by 0.6 centimeters was detected at the gastrojejunal junction. At that time, the blood urea nitrogen was 32 milligrams per cent. The urine was neutral with a specific gravity of 1.028, protein 0, sugar 2 plus, acetone 0. The hemoglobin was 7.9 grams, hematocrit 24. The alkaline phosphatase was 2 Bodansky units.

Following discharge from the hospital the patient continued to have loss of appetite. He then began to have increasing urinary frequency and nocturia. Shortly before his final admission to the hospital he became disoriented and semistuporous. He appeared dehydrated and had poor tissue turgor. His blood pressure was 120/70, pulse 110, respirations 20, and he appeared pale. A few crepitant rales were heard at the left base but physical findings otherwise were essentially negative.

The blood urea nitrogen was 10 milligrams per cent and the blood sugar 174. The sedimentation rate (Westergren) was over 100 millimeters in 1 hour. The hemoglobin was 12.2 grams per cent, hematocrit 37.5, red blood cells 3,720,000, carbon dioxide 73.6 vol. per cent (33.2mM/l), chlorides 100 mEq, sodium 134 mEq, potassium 4.0 mEq., and transaminase 9 SGP units. The serum amylase was 51 Somogyi units (normal 50 to 150). The urine contained a trace of protein and no sugar or acetone. The electrocardiogram revealed moderately fast sinus rhythm with horizontal electrical position of the heart. Chest x-ray showed a faint density at the right base, possibly a pulmonary infiltrate or soft tissue density in the chest wall. The skull x-ray was negative. Another urine examination revealed myriads of calcium phosphate crystals.

The patient improved at first after fluids were forced in the effort to relieve dehydration. Eight days after admission he developed respiratory irregularity of Cheyne-Stokes type and became semiconscious. His urinary output dropped almost to zero. Lumbar puncture revealed clear cerebrospinal fluid with a count of one mononuclear cell, sugar 164 milligrams per cent, protein 40, chlorides 120. At this stage the patient's serum calcium was found to be 12.2 milligrams per cent, the phosphorus being 2.5 and blood urea nitrogen 20. The history and laboratory findings suggested the possibility of hyperparathyroidism. The patient's 24 hour output of calcium was found to be 530 milligrams, a figure well above the normal range. Urinalysis now showed numerous red blood cells in the sediment. Repeated blood chemistry determinations revealed calcium ranging about 12.5 milligrams per cent. High speed radiography of the cervical esophagus during swallowing revealed no evidence of indentation by an enlarged parathyroid. The patient's mental state remained clouded and he continued to be disoriented.

Sixteen days after admission the patient's neck was explored and one of the parathyroids was removed. Histologically it had the appearance of normal parathyroid gland with some chief cell hyperplasis but no evidence of adenomatous overgrowth or true adenoma. Postoperatively the serum calcium rose to 18.4 milligrams per cent and his general condition deteriorated progressively. The possibility of mediastinal parathyroid adenoma was considered again, especially when the serum calcium rose to 13.6 milligrams per cent, but his general condition was precarious and he died three weeks later, cause of death was bronchopneumonia.

Autopsy Findings: Dissection of the neck revealed no evidence of parathyroid tumor. In the lungs, a mass four centimeters in diameter surrounded the right main bronchus and bulged into its lumen to produce a mild obstruction. The outer part of the mass extended almost to the pleural surface of the right upper lobe. Histologically, this was a highly anaplastic epidermoid carcinoma. The cells were large and irregular and the nuclei were bulky and markedly hyperchromatic. Occasional tumor giant cells were present. The tumor infiltrated the outer coat of a large branch of the pulmonary artery. The regional nodes about the right main bronchus were partly replaced by tumor.

The liver surface was studded with numerous tumor nodules and similar nodules were revealed within its substance. These metastatic nodules resembled the primary lung cancer histologically. No metastases were found in other tissues.

Sections of vertebrae revealed rather thick trabeculae with limited erosion by osteoclasts. Many of the trabeculae had a pagetoid mosaic appearance produced by exaggeration of the cement lines.

The adrenal cortex exhibited moderate uniform hypertrophy and a few small adenomatous nodules.

The pituitary was cellular and exhibited patchy adenomatous hyperplasia of eosinophile elements and similar hyperplasia of basophile cells, many of which contained large vacuoles.

The kidneys showed scattered foci of tubular calcification within the cortex accompanied by mild reactive inflammation. Masses of partly calcified cellular detritus were present within the lumen of some of the calyces.

The high serum calcium associated with low serum phosphorus, as in the cases cited by Plimpton and Gellhorn[6] had led to the clinical suspicion of hyperparathyroidism, which however was not confirmed by exploration of the parathyroid glands. The finding of essentially normal parathyroid glands in the presence of clinical hyperparathyroidism suggests, therefore, the primary role of the pulmonary tumor in the aberrant production of a parathormone-like material.

One of the lessons of this case is the reminder of the wide variety of metabolic and other effects which may dominate the clinical picture of lung cancer and mask its presence.

The carcinoid syndrome has been reported frequently in tumors of the lung, not only in typical carcinoid tumors of the lung but also in other types of lung tumor, including oat cell carcinoma.[8] Insulin and glucagon have been identified in the metastasis of a bronchogenic carcinoma,[9] and in several instances[10] hyponatremia has been described related to inappropriate secretion of antidiuretic hormone. Syndromes resembling myasthenia gravis,[11] severe orthostatic hypotension,[12] and gynecomastia[13] have also been described in cases of pulmonary cancer.

When a person develops Cushing's syndrome abruptly (and in marked severity), he should be examined specifically for the possibility of lung cancer. The clinical picture of hyperparathyroidism of equally abrupt onset and unusual severity, progressing quickly into hypercalcemic coma as in the case just described, should similarly arouse suspicion of lung carcinoma, especially if exploration of the parathyroids in the neck reveals hyperplastic[2] or normal parathyroids and not an isolated adenoma.

Summary

The case of a patient with unrecognized lung cancer is reported in which the clinical picture of anorexia, polyuria, profound weakness, and hypercalcemia suggested hyperparathyroidism with hypercalcemic crisis. Normal parathyroid glands were found at surgical exploration and the patient died in coma six months after the onset of symptoms.

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180 Somerset Street

The Silver Anvil

The American Medical Association has been awarded the prestigious "Silver Anvil" trophy for its Volunteer Physicians for Viet Nam Program. The AMA entry in the 26th annual competition conducted by the Public Relations Society of America won the top honor in the "International Public Relations" category. Since 1966, the AMA has recruited over 700 U.S. physicians to serve 60-day tours in South Vietnamese civilian hospitals and clinics. Under an agreement with the U.S. Agency for International Development, the AMA meets a minimum quota of 32 volunteer physicians every two months. Volunteers receive round-trip transportation, housing, and $10 daily expenses while in Viet Nam.

Physicians interested in serving should contact the Department of Military Medicine, AMA, 535 North Dearborn Street, Chicago.

Carcinoma of the small bowel is rare, and particularly rare when it involves a malignancy of the villous adenoma. This case, therefore, is of special interest, including the gratifying outcome.

Duodenal Obstruction Due To Malignant Villous Adenoma*

Report of A Case

William A. Dwyer, M.D. and Richard F. O'Brien, M.D./Paterson

In the spring of 1969, a 73 year old woman was admitted to the psychiatric service of St. Joseph's Hospital with a history of recurrent vomiting. After extensive workup (including a gastrointestinal series which proved negative), she was discharged on tranquilizing agents only to be readmitted two weeks later with a severe exacerbation of her symptoms. Prior to making a decision as to psychiatric commitment, another gastrointestinal series was obtained. This showed an obstructing lesion of the third portion of the duodenum, (see Figures 1 and 2). After correction of an electrolyte imbalance (mild hypokalemic alkalosis) attributed to vomiting, a surgical exploration revealed an annular lesion of the duodenum invading the serosa with metastases to two adjacent lymph nodes. The entire distal duodenum and beginning jejunum were resected, together with the involved lymph nodes, and an end-to-end enteroenterostomy constructed to restore bowel continuity. The patient's postoperative course was uneventful. By the second postoperative day, most of her psychiatric symptoms had disappeared. By the fourth postoperative day, she was on a regular diet. She was discharged to her usual residence by the ninth postoperative day.

Until this point, this was a somewhat unusual and rather gratifying surgical case. Close inspection of the specimen in the pathology department, however, showed it to be a very rare case indeed. On opening the specimen, it was immediately obvious that the carcinoma was arising in a villous adenoma which involved the mucosa in sessile fashion for some distance on both sides of the malignant tumor (see Figures 3 and 4.)



Figure 1

* From the Department of Surgery and the Department of Pathology, St. Joseph's Hospital, Paterson, New Jersey.



Figure II



Figure IV

Microscopic appearance of tumor illustrating its villous appearance and invasiveness.



Figure III

Gross appearance of resected tumor.

Any tumor of the small bowel is an unusual finding. Carcinomas of the small bowel are still more unusual. Ostermiller, *et al.*[1] report that malignant lesions of the small bowel comprise 5 to 6 per cent of all gastrointestinal tumors and 1 per cent of all malignant tumors. Ebert, *et al.*[2] put the incidence at about 1 per cent of all gastrointestinal tumors.

Carcinomas of the duodenum appear to be the most common of the small bowel malignancies. Bockus[3] reports that carcinoma of the duodenum accounts for 3 per cent of all intestinal malignancies while other authors report that, inch for inch, the duodenum is more likely to undergo cancerous change than the jejunum or ileum.

Surprisingly, despite the existence of a number of excellent reviews of small bowel tumors, there is no mention in the literature of villous adenomas of the small bowel until

Moersch's case report[5] of 1962. Indeed, Bockus[3] discusses this tumor in the section on the colon and makes no mention of its possible occurrence in the small bowel.

In 1968, Bremer[6] *et al.* published a clinical review and case report in which they document 92 such tumors in the upper gastrointestinal tract. They found ten such cases in the small bowel, of which six were located in the duodenum.

Summary

Very little attention has been paid to the existence of villous adenomas of the small bowel. While these are rather unusual, they do cause bleeding and obstruction of the gut and have a high malignant potential.

The ease with which this case could have been missed completely, together with its eventual gratifying outcome and its unusual pathology have moved us to report it. It is our feeling that it is illustrative of the old adage, "Seek, and ye shall find."

The authors wish to acknowledge the help of Miss T. Moir in the preparation of this paper.

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412 Park Avenue

Small Town Practitioners

A random sample of 2,468 physicians practicing in U.S. nonmetropolitan areas was surveyed by the American Medical Association. The findings are published in *Public Health Reports*, Vol. 85. Compiled by Bond L. Bible, Ph.D., secretary of the AMA Council on Rural Health, the responses of 1,853 physicians indicated:

The majority of smalltown practitioners and their wives had smalltown backgrounds; similarly, physicians in communities of 25,000 or more generally were reared in comparably sized cities.

Influences on choice of practice sites were "best opening," geographic preferences, family and friends, leads from colleagues or others, nearby place of internship, and assistance from AMA and medical society placement services.

Fifty-eight per cent were engaged in solo or individual practice, 17 per cent in group practice, and 25 per cent in various combinations.

Rural physicians prefer the slower pace, closer social ties, and greater outdoor recreational opportunities, and share concern over access to continuing education programs, opportunities for professional growth, hours of practice, available facilities and personnel, and emergency services, especially in isolated rural counties.

Copies of the survey are available from the AMA Department of Community Health, 535 North Dearborn Street, Chicago 60610.

In many a modern hospital today more patients are handled in the emergency department than in all the wards, private rooms and out-patient clinics put together. Here is a new specialty: emergency medicine.

The Emergency Department Of A Modern Hospital

Robert L. Wegryn, M.D./Elizabeth

Since World War II, the old accident rooms of hospitals have grown into extensive and involved departments. Prior to 1940, the accident room in most hospitals was a single room with a stretcher and casting material where auto accident patients were brought. The total census was between zero and ten patients a day. One nurse covered this department on a part-time basis. Today the Emergency Department is the busiest patient care center of the hospital. Thus, at St. Elizabeth Hospital (Elizabeth, New Jersey) there has been almost a 300 per cent increase in the patient load in the last ten years. National figures show an average increase in Emergency Department loads of 14 per cent per year over the past ten years.

Why is this change in patient care occurring? One can think of at least seven reasons.

1. Patients are learning that doctors are available 24 hours a day. Fifteen years ago there were 95,000 general practitioners (family doctors) in the United States. Today there are only 68,000 and only 45,000 of these are treating patients full time. During the same time, our population has increased 40 per cent. The doctor to patient ratio in this country has been decreasing markedly over the last 15 years and is expected to be of critical significance within the next ten years.

2. Formerly transportation was a problem. Today, most patients can get to an Emergency Department in a short time by car or ambulance.

3. The fluidity of our population today often means that a family has not had time to develop a "family physician" to whom they can turn when they find themselves in trouble. These people have begun to look upon Emergency Departments as a community medical center.

4. With our marked degree of subspecialization, the doctor a family has used for one of their medical problems is not suited to treat them for their new problem outside his specialty. Thus, the obstetrician who delivered the family's baby is not willing or trained to take care of dad's cut finger.

5. The cost of Emergency Departments' visits to patients with certain types of insurance coverage is often lower than an office visit. An Emergency Department visit may be covered by certain insurance policies, whereas an office visit for the same complaint is not.

6. The alarming increase in automobile traffic has greatly increased Emergency Department visits from accidents. In 1968, 112,000 people were killed in the United States due to some form of accident. This is the leading cause of death for people under 35. Motor vehicles caused 53,000 deaths in 1967. More people die in one year from automobile accidents than have died in any year due to battlefield casualties. Fewer than one million men have been killed in the United States during all wars from the American Revolution to Viet Nam. Over one million people in America have died, however, *in the last fifty years alone* due to highway fatalities. Over two million disabling injuries occur a year secondary to automobile.

7. Many doctors are now referring their patients to the Emergency Department, because of the availability of nurses, interns, technicians, and consultants who can make their work easier.

At Saint Elizabeth's Hospital 55 per cent of our patients are seen as a result of some form of accident. Most of these are accidents occurring at home, at work, or on the street. About 10 per cent are due to auto accidents. A fourth of our Emergency Room patients require X-rays.

There is a tremendous preponderance of children under 10 years of age seen in our Emergency facility. Ages 10 through 19, and 20 through 29 are also heavy visitors. Apparently, by age 30 most people have learned how to keep away from accidents. Senior citizens are infrequent visitors to the Emergency Room.

The bulk of our patients comes in between 10 a.m. and 10 p.m. There is a peak of patient visits between 7 and 9 p.m. in the evening. Many patients, apparently, wait for dad to come home from work or supper to be over before coming in with their "emergency" condition. Other peaks occur at 10 a.m. and 1 p.m. Saturdays and Sundays are our heaviest days. Wednesday (the other doctor's day off locally) is the third busiest day of the week. The majority of our patients say that they have come to the Emergency Department on their own initiative. Only 5 per cent say that they had been sent by a physician, and 18 per cent by some agency such as police, school, or companies. Many industries refer their injured patients to hospital Emergency Departments rather than a physician's office.

About 10 per cent of the patients we see require admission to the hospital. Of these, just over half are admitted to the Medical Service, about 40 per cent to the Surgical Service, about 4 per cent to the Pediatric Service, and only 1 per cent to the Gynecology Service. Patients in labor are not counted in our Emergency Room statistics, even though they are seen by and checked in the Emergency Department.

Forty per cent of the patients assert that they have no insurance at all. Since over 85 per cent of people living in this area are covered by some form of hospital insurance, we conclude that the indigent citizen often uses the Emergency Department as his private physician. Only 2½ per cent of the Union County population is on welfare, but 13 per cent of the patients seen in our Emergency Department are getting this type of public assistance.

Some years ago, in Rochester, New York, Dr. David Kluge and I tried to find out how many of the patients at the emergency room of the Genesee Hospital were *bona fide* emergencies. We divided the patients into three categories, no, yes, and mixed. The "no" category indicated conditions which either did not require the advice of a doctor or ones which easily could have waited 24 hours or longer for attention. This included such things as, "a cold for two weeks," "a sore throat for five days," or "removal of sutures." The "mixed" category was for conditions which by their nature should be seen before a 24-hour period had elapsed, but which did not need the availability of hospital facilities. For example, a sudden fever in a child, a sprained ankle, cuts, or bruises.

The "yes" category was used to indicate conditions which fulfilled two criteria: (1) problems which by their nature should be seen immediately by a doctor, and (2) problems which by their nature are likely to need facilities present only in a hospital, such as x-rays, operating rooms, nurses, and so on. This would include a car accident even if no serious injury were found, an "acute abdomen" even if due to a virus infection, and chest pain even if due to a "cold." About one-third of the patients fits into each of the three categories. Thus, two thirds of the patients had problems which could have been handled on the phone, in a clinic, or in a doctor's office. I have not yet had a chance to duplicate this study in Eliza-

beth, New Jersey, but I believe that a higher ratio of our patients are truly "emergency cases."

At Saint Elizabeth Hospital, the emergency room is covered by five full-time licensed physicians. Each physician has no other practice outside of the Emergency Department. They see 95 per cent of the patients brought into our facility.

Eight per cent of the patients brought to our emergency room are brought in by ambulance. Half of these come in our own ambulance and half by volunteer ambulance companies from the surrounding areas. This does not include patients transported directly to a bed in the hospital but only those patients transferred to the Emergency ward by ambulance.

As the number of general practitioners throughout the country has decreased, we are starting to see a rise in a new specialty called Emergency Department Medicine. Two medical schools have already initiated training programs for this type of physician. A new national medical society has been formed for Emergency Room physicians. Europe has for years had the medical specialty of traumatology with special hospital and training facilities.

Today more patients are being cared for in our emergency department than are being cared for in the entire rest of the hospital, including all of our out-patient clinics. More cardiac arrests are cared for in the Emergency Department than in the rest of the hospital. Most of our critically ill patients are cared for first in the Emergency Department.

Emergency Department care is perhaps no longer the stepchild of hospital operations. However much more remains to be done.

225 Williamson Street

Your Patient's Disability And Rehabilitation Claims

Your paperwork burden may be lightened under new procedures worked out by the Medical Society and the New Jersey Rehabilitation Commission — Disability Determinations Service.

Formerly, when a patient applied for social security disability benefits, you got a standard report form from him or, in most cases, from a social security office acting in his behalf. If further information was needed, you received a follow-up request from a reviewing physician at the Disability Determinations Service, where social security disability claims for New Jersey residents are evaluated.

Now even the first request for medical evidence will usually come from your colleague at the State agency. His queries are in many cases expected to be specific and selective, saving you time and effort. As a result, requests for additional information are less likely.

It is your report, from information in your files, that enables your patient to meet his obligation under the law to provide initial medical evidence to support his claim for disability benefits. If there is a charge for this report it is, therefore, your patient's responsibility. Our State Rehabilitation Commission is confident you will continue to give the social security disability program your full cooperation in helping to secure prompt and proper decisions for patients.

Offered here is a review of what is new in the management of coronary disease.

Coronary Heart Disease*

New Aspects of Prevention and Treatment

William Likoff, M.D./Philadelphia

Two major concepts dominate our thinking about the manner in which atheroma forms. One concerns the accumulation of blood platelets upon a diseased endothelial lining. The other deals with some type of metabolic error involving lipids. Both theories have an ancient lineage going back about a century.

Today the platelet conglutination theory seems to have the upper hand. Blood platelets clumped at a predisposed site in the vessel wall constitute the initial phase of thrombosis. Clotting occurs in the column of blood trapped behind the platelet mass. Once platelets aggregate against the vessel wall they tend to set up a chain reaction involving the activation of prothrombin to thrombin which causes the clumped platelets to become more sticky so that they fuse together into a viscous mass. This part of the process may depend on the balance between clot-promoting and clot-inhibiting elements in the blood. Anticoagulant drugs, particularly heparin, may inhibit thrombin formation but only when given in exceptionally large dosage.

What causes the platelet to localize at a particular site is not only increased adhesiveness of the platelets (and this may vary from time to time) but also some local abnormality in the vessel wall which allows platelets to make contact with the connective tissue just beneath the endothelial lining. How this happens is not clear. Local injury may create a "current of injury" so that the electronegative platelets become attracted to a site where the wall has become electropositive. Endothelial cells can actually become partly detached like a flap to expose the underlying tissue and allow materials in the blood to permeate the wall of the vessel. This tendency can be greatly increased when the wall is diseased.

Another factor is the hemodynamic action of eddy currents and turbulences in the rapidly flowing blood stream which tend to fling platelets out of the center of the blood column toward the outer zone nearest the vessel wall. These eddy currents are generally found at areas of bifurcation of an artery (or vein).

In coronary arterial disease, the localizing action of turbulent flow on platelet deposition is seen in impressive form just above sites where a main stem coronary artery gives off a major branch. One of these is where the left coronary artery gives off its anterior descending branch and continues as the circumflex artery. Another is just proximal to the take-off point of the marginal branch of the right coronary artery. This concept of atherogenesis accounts for the segmental nature of atherosclerosis. Rarely does one find a coronary artery atherosclerotic in the same degree throughout its length. Often there are stretches in which little or no disease is present.

The original mass of agglutinated platelets tends to become fused into a solid adherent lump which is difficult to dislodge. As the artery tends to enfold the lump in order to restore a smooth inner lining, the embedded

*Given at Postgraduate Course, Middlesex General Hospital, New Brunswick, New Jersey, January 22, 1969.

mass of platelets becomes a source of local irritation and inflammation. This in turn favors seepage of additional materials from the blood, particularly lipids as well as calcium salts. As the platelet mass is progressively resorbed, leaving behind only insoluble lipid residues, the entire mass takes on the features of "atheroma." Because of its mushy, porridge-like character it has been spoken of as an "atheromatous abscess." Its capsule, being quite hyperemic, easily develops secondary hemorrhage which may enlarge the mass further. Now, flow through the artery at this point is hindered directly by the bulging atheroma, which also creates secondary eddies and turbulence effects tending to increase further the accumulation of platelets.

Finally the ripe atheroma may rupture into the lumen, extruding its contents into the moving blood current, which carries the irritating material into the farthest reaches of the arterial tree producing a form of microembolism in that part of the heart sufficient to produce much localized myocardial damage. The exposed bed of the ruptured atheromatous "abscess" now becomes rapidly filled with fresh thrombus which may bring about complete closure of the lumen.

Any approach to prevention and treatment of coronary atherosclerosis must be shaped to conform with the three basic factors concerned: (1) the original cause of vascular injury which predisposes to thrombosis, (2) the number and adhesiveness of blood platelets which are the initiating factor in the thrombosis, and (3) the evolution of the thrombus into "atheroma," which produces mechanical interference and triggers further thrombosis. Anticoagulant treatment given in the usual manner can accomplish little when the primary basis of atheroma is platelet aggregation rather than blood clotting.

Lipid Metabolic Errors

Because the atheroma is rich in lipid it is not surprising that pathologists assumed that it resulted from an error in lipid metabolism. This assumption obtained support from animal experiments. When diets excessively rich in lipids were fed to thyroidectomized dogs and to herbivores, such as rabbits, which metabolize lipids with difficulty, massive deposits of lipids accumulated in many tissues, including the walls of arteries, especially at sites of hemodynamic stress. And what seemed to confirm the lipid concept of atherogenesis (in spite of some objections) was the apparent correlation between abnormalities in serum lipids and the predisposition to atherosclerosis in human subjects. People with excessively high blood lipids seemed to develop precocious atherosclerosis. Distinct correlations could be shown between specific types of lipid abnormality and the tendency to atherosclerosis, particularly Type 4 and Type 5 of Frederickson's classification. These types include most atherosclerotic people with high fasting levels of triglyceride and are characterized by accumulation of pre-beta lipoprotein. Type 4 is the basic type. Type 5 actually representing a variant of Type 4 in which there is also some chylomicron retention. In Type 4 hyperlipoproteinemia, the patients are usually adult males and almost always under treatment for vascular disease. Nearly all of these have abnormal glucose tolerance curves similar to those of diabetes mellitus but actually are suffering from a separate carbohydrate disease. The abnormal lipoprotein (pre-beta lipoprotein), which contains the marked increase in triglyceride, depends upon increased intake of carbohydrate rather than lipid, i.e., is carbohydrate-induced.

In summary, atherogenesis may be broadly defined as the result of a biochemical or biophysical fault of the vascular lining associated with a platelet conglutination error complicated by derangement in lipid metabolism.

With these considerations in mind one should re-examine the timeworn postulates which have grown up about the whole question of coronary heart disease. To what extent should one be concerned with exercise, smoking, diet, stress or any other specific factors?

According to older studies of autopsied hearts

the right coronary artery was the predominant supply artery in 50 per cent of hearts, the left in 15 per cent. Both had a balanced distribution in the remaining 35 per cent. Results of a massive survey of the population through coronary arteriography in the last few years have changed our viewpoint radically. At present the distribution of the two coronary artery systems to the ventricles is as follows:

Right coronary artery preponderance	90 per cent
Left coronary artery preponderance	4 per cent
Balanced pattern	6 per cent

The artery chiefly involved in severe and fatal coronary arterial disease is the left coronary artery, particularly its short proximal segment beginning about 4 millimeters beyond its origin, where it gives rise to its major branches, the left anterior descending and the left circumflex arteries. The distribution of the coronary arteries bears no correlation with the physiologic "responsibility" of the artery. This is apparent from the fact that the left coronary artery is the vessel responsible for the blood supply of a far greater amount of muscle tissue than the right coronary artery. Accordingly the left anterior descending coronary artery, when it becomes occluded by atheroma, has the potential of being the most lethal segment of the entire coronary tree. The left circumflex artery and right coronary follow in order of potential threat. The posterior descending and right marginal arteries are much lower on the scale.

Reduction in Caliber

We can take hope in the fact that the anastomoses between the major branches as well as between branches of the same artery may be sufficient to minimize the ischemic damage, possibly even to prevent it. But we must restrain our impulses to interfere with nature's way of making adjustments. When we reduce the work of the heart in treating the coronary patient, for example when we give the patient nitrites, beta blockers, and so on, we are not necessarily following the prescriptions of nature. Thus, when the heart is in a state of anaerobic metabolism (e.g. as a result of advanced fibrosis) the amount of lactic acid formed in the heart muscle is greatly increased in relation to pyruvic acid. Such a heart should be rested by reducing its work load. When the opposite condition prevails it may be undesirable to attempt to reduce the work load because the challenge of a work load ordinarily tends to stimulate the heart to improve its function and to call forth a better collateral blood supply. Technics are now available in research centers for measuring the lactate metabolism of the heart. In clinical practice one simply inquires about the symptom which reflects the presence of "anerobic metabolism," namely *fatigue*.

Workup of the Coronary Patient

History: A proper history is something that cannot be developed by a simple check-off list or questionnaire. When the clinical picture is atypical, the history may be quite valueless or may have enormous significance. The true picture is brought out only if the history is acquired by a searching *dialogue* between the doctor and the patient. For example, suppose a patient may complain of recurrent chest pain lasting 4 or 5 hours. By computer standards this rules out angina pectoris since the duration of angina is measured in minutes rather than hours. Conversation with the patient may reveal that his pain was phasic, lasting 10 minutes at a time and recurring every 40 to 60 minutes over a period of 4 to 5 hours. In this case we are clearly dealing with the anginal syndrome.

Physical Examination: Perfunctory auscultation yields little as a rule in the evaluation of coronary heart disease. When one applies the stethoscope to the chest of a suspected coronary patient he should apply it in a conscious deliberate search for specific findings which may have meaning. Among these may be the following:

a. Presence or absence of arrhythmia.
b. Presence or absence of gallop.
c. Presence or absence of a holosystolic murmur at the apex, which may indicate papillary muscle dysfunction or rupture.

Further analysis of murmurs may identify sclerosis or dilatation of the aortic ring.

Electrocardiogram: The presence and the absence of changes in the ECG are important only if taken in proper perspective. If the ECG has been abnormal previously, subsequent changes reflect an evolving disease pattern. Abnormalities appearing for the first time in a patient whose previous tracings have been consistently normal are even more significant.

Coronary Arteriography: Coronary arteriography is generally utilized to evaluate the indications for surgical revascularization of the heart or as part of large investigative surveys. Coronary arteriography should also receive application in differential diagnosis of obscure cardiac disorders which cannot be clarified by other measures. It should not be applied too freely and too casually so that one tends to lean on it.

The Physiological Workup: Examination of the capacity of the heart to tolerate an applied load is just as important as coronary arteriography. This information supplements coronary arteriography and helps in the evaluation of patients with severe cardiac dysfunction whose arteriogram falls short of showing the expected anatomic lesions. Such disparity occurs in many diabetics, in whom abnormal cardiac metabolism conditions the relative degree of coronary arterial insufficiency.

The exercise tolerance test with the "bicycle" measures cardiac function in terms of changes in ECG and in pulmonary artery pressure. If pulmonary artery pressure rises to an excessively high level during physical exertion, even though normal at rest, the patient is clearly suffering from left heart failure and needs digitalis. The patient himself serves as his own diagnostic device if he describes the occurrence of *dyspnea* during exertion.

Thus, in a crude way, it is possible to gain some idea of the type of metabolism by asking the patient whether or not he develops excessive fatigue after a period of activity. If he does, one can assume that his heart is in a state of relative anaerobic metabolism. The symptom of fatigue is extremely important and should never be ignored. It is the important warning against added strain, for example exercising in the hope of increasing collaterals.

Exercise has an important place in the rehabilitation of the patient with heart disease. Whether exercise plays any role in reducing the tendency to atherogenesis is questionable except possibly by the effect of exercise in lowering serum lipids. Because of the effect of training on cardiac performance, regular physical activity appears to improve cardiac performance and in this way improves one's chances of weathering future attacks of myocardial infarction.

The "trained" heart performs more efficiently, producing a given output of work at much lower cost of energy. This is revealed by the relatively slow pulse and low blood pressure during exertion compared with the untrained heart. Exercise enables the heart to conserve its energy by functioning in a more economical way.

Digitalis in Treating the Coronary Patient: The risks of digitalization have been perhaps somewhat exaggerated. Some danger exists, particularly *fatal arrhythmia,* but only with toxic doses.

The combination of angina pectoris and *dyspnea* is a signal that the patient is suffering from left ventricular failure. Digitalis will improve cardiac performance and also relieve angina.

Nitrites relieve cardiac pain by reducing peripheral vascular resistance and blood pressure, thereby reducing the cardiac work load. Nitrites, propanolol and similar agents, which reduce the work load of the heart, may increase the degree of dyspnea when there is failure of the left ventricle. If these drugs

produce dyspnea the patient also needs digitalis.

Myocardial Infarction: Bed rest and treatment of the patient's discomfort, e.g. with Dilaudid,® are the mainstay of treatment. Anticoagulants are indicated if there is a strong probability of mural thrombosis and peripheral embolism, particularly in the case of severe myocardial infarction requiring the patient to be bedridden for a long time. If there is evidence of heart failure, cardiogenic shock, and various arrhythmias the patient must be treated aggressively. Levophed® and Isoproterenol® should be used only temporarily because they increase the tendency to arrhythmia and increase the need of the heart for oxygen. If the decision is made to place the convalescent patient on anticoagulant therapy for a prolonged period of time it is rational that anticoagulant therapy should be maintained for life.

Intractable Angina Pain: In the case of intractable angina one must determine whether or not it is proportionate or disproportionate to the work load. Angina in a steel "puddler" has a different meaning from angina in a bookkeeper. The same reasoning applies to angina occurring chiefly under strong emotional pressure or untreated hypertension. Intractability is hence a relative term. Intractable angina of crescendo type is representative of impending myocardial infarction.

What lies open to the individual patient is to reduce the work of his myocardium or to treat him surgically. Radioactive iodine may reduce cardiac work load on a permanent basis provided a dose is given which will not ablate thyroid function totally but come closer to a 50 per cent reduction in function.

A special type of problem concerns a certain group of patients, particularly women within an age group 33 to 50 who are suffering from repeated angina. Coronary arteriography shows virtually normal coronary arterial system.[1] All physical findings and results of other studies are essentially normal and doubt may exist whether organic disease is present. ECG changes of minor degree may eventually become evident. In two cases the patient developed transmural infarction of the myocardium.

The nature of the underlying abnormality in this syndrome is quite mysterious. Arteriography, ventriculography, work studies, metabolic studies, and all other studies have for the most part, shown no clear basis for the syndrome. Some hint exists that the syndrome is associated with an anaerobic type of metabolism in the heart muscle. Other findings that have been reported include an abnormal oxygen dissociation curve. In perhaps a third of the cases the pain is somewhat atypical and in only about half the cases is the pain relieved by nitroglycerine. The usual therapy for coronary heart disease in these cases is both ineffective and unwarranted. The importance of recognizing the syndrome is to identify it and save the patient needless additional workup and therapy.

[1] Likoff, W., Segal, B. L., and Kasparian, H.; Normal Selective Coronary Arteriograms in Coronary Heart Disease. *New England Journal of Medicine.* 276:1063 (May 11, 1967).

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Most of us are skeptical about crash programs, but here is an encouraging report of at least one practitioner's experience.

Crash Treatment For Melancholia

Resistant To Other Recently Developed Methods

Theodore R. Robie, M.D./Montclair

During the decade following the introduction of chemical anti-depressant agents a revolution has occurred in the treatment of melancholia. Some psychiatrists had grown accustomed to the improved application of electroconvulsive therapy, which had eliminated the threat of skeletal fracture (these had occurred in about a fourth of all cases receiving shock therapy in the early forties). These doctors were reluctant to give up electro-physiologic treatments in favor of the newer anti-depressant chemotherapy. However, more than half of the psychiatrists in 1959 and 1960 began to use chemotherapy in place of shock therapy. In my own practice, by 1965, chemotherapy had replaced shock therapy in some 75 per cent of melancholy patients and the figure became 85 per cent by 1966. By 1969, the figure was well over 95 per cent.

Many psychiatrists were administering either amine oxidase inhibitors or cyclothymic chemicals and were having a high ratio of satisfactory recoveries. However, there were some unsatisfactory results. Potentiation of these chemical therapies was sought by those who did not wish to revert to shock treatment, against which many patients protested. Once chemotherapy has been instituted, the patient should experience the process of recovery as quickly as possible to establish hope in complete remission of symptoms.

Therefore, I enthusiastically embraced the suggestion by Dr. Alphonse Flora† that the dissemination of serotonin could be increased extraordinarily throughout the body by introducing 5 hydroxy-tryptophan into the blood stream and then converting it into serotonin (5 hydroxy-tryptamine) by parenteral injection of methyl phenidate (Ritalin®).

We learned very quickly that combining this intensification of serotonin dissemination with any one of the amine oxidase inhibitors administered orally could induce remission of severe depression more rapidly than by administering oral anti-depressants alone. This could be conveniently administered in the office *via* bed treatment requiring only 2 to 2½ hours of time, this regime being given three times per week. One nurse can safely care for three such patients at a time if bed facilities are available. Most doctors could add a small bed to an examining room and could thus treat one patient at a time while carrying on other office responsibilities. The doctor's attendance is usually necessary only for the two intravenous injections, but is always available for any technical need, such as deciding dosage, as each 2½ hour treatment proceeds. The nurse records sitting and standing blood pressures at 15 minute intervals which provide the treating physician with a panoramic picture of each patient's progress by occasional quick observation of this information on a single data sheet.

This simple procedure should be available to the many melancholy persons seeking help. Physicians, other than psychiatrists, could give these treatments when they recognized the

†The Ciba Pharmaceutical Company of Summit, New Jersey supplied the Ritalin® for this study.

need. I have given them in my day hospital set-up for the past five years.

In most cases oral treatment alone will extract sufficient serotonin from the cells by the oral MAOI therapy to induce remission. But if marked improvement with oral medication has not occurred by the fourth week, this intensified treatment is necessary. If not given, the patient could slip back into a potentially suicidal state. However, this intensified serotonin regime usually induces symptomatic recovery within five weeks which is quite different from the patient's slipping back into a morass of melancholia with no hope of resuming his occupation.

Any patient who is not progressing satisfactorily on thymoleptic anti-depressants (Imipramine®, Elavil®, Norpramine®, Aventyl®, or Pertofrane®) should have the thymoleptic discontinued and after a three day interval with no therapy other than oral Ritalin®, he should then be placed on MAOI therapy, and a week or two later can be started on this intensified serotonin regime. In a short period, a good remission can be expected.

Serious incompatibilities may result in hyperpyrexia. A lethal outcome may occur in changing a patient's medication from MAOI chemicals to thymoleptics and *vice versa*. However, it takes much longer to get all the MAOI out of the system than it does for the thymoleptics. Because of this lost time, I start all my depressed patients on MAOI therapy so there need be no delay if intensified therapy becomes imperative to induce remission. Some conservative chemotherapists advise a longer delay than three days before MAOI chemicals are started after thymoleptics have been discontinued.

In 1957, I confirmed Kline's findings that remission of melancholia could be induced by adequate dosage of iproniazid administered orally, without electro-convulsive therapy. This new chemical brought with it a new complication: *hypotension*. This may be induced by the new drug.

Since 1957, several other amine oxidase inhibitors have been synthesized (namely: Eutonyl®, Nardil®, Niamid®, Parnate®, and Marplan®) by our ethical pharmaceutical manufacturers and all of these are being used to induce remission of melancholia. However, any one of these *may* fail, and in these cases the serotonin intensified therapy becomes imperative.

Most of my patients are ambulatory. I decided to teach the patient or relative to record blood pressures at home. The Taylor Instrument Company lent me their best sphygmomanometers for this purpose. To prescribe anti-depressants without frequent *sitting* and *standing* sphygmomanography is foolhardy.

Each patient is given forms for recording sitting and standing blood pressures daily (or twice daily if indicated) and is instructed to phone me when systolic pressures fall below 100. Instructions are then given for immediate treatment and an earlier office visit is scheduled. Each patient is given a small supply of Florinef® for emergency use and thus can be instructed, at any time, to take dosage sufficient to preclude syncope, or other weakness that is experienced.

In 1963, I first reported the use of of Florinef® as a useful anti-hypotensive. It requires one quarter to one half tablet of the 0.10 milligram size, once or twice daily, to maintain ambulant stability. If Florinef® is taken when hypotension persists (because of need for larger than usual doses of MAOI) hyperpotassemia may occur. This can be controlled by K-Plex® or KAON® with reduction of MAOI and later of Florinef.®

It has become a routine procedure to secure SGO-Transaminase tests regularly when using MAOI or thymoleptic medication.

Whenever 5-HTP is used to produce a satisfactory MAOI enhancement, one will induce considerable degrees of persistent hypotension

with attendant dangers. Because of latent severe hypotension, Florinef® is given prophylactically. The hypotension may endure several days or even weeks but the patient can be kept ambulant by adequate Florinef® dosage.

The serotonin deficiency is chronic in most cases. The depression can be maintained in remission by gradually decreasing dosage of MAOI to perhaps a fourth to an eighth of the original dosage. Office visits can then be reduced to every four to six weeks, particularly in those who record dual blood pressure thrice weekly.

With Marplan® as the prototype, I start with 10 milligrams t.i.d. and if no hypotension occurs in the first few days, dosage is increased to 40 milligrams per day, unless improvement is apparent. This is reduced to 30 milligrams when improvement is apparent and kept at 30 for the next two or three weeks. The dose is then reduced to 20 or 25 milligrams a day, guided by the transaminase tests, blood pressure readings, and clinical picture. In the fourth or fifth week, if improvement persists, dose can be reduced to 15 milligrams per day and gradually (in the sixth to eighth week) to 10. This level is continued for about a month before reduction to 5 or 7½ milligrams. The office visit can now be every three or four weeks. If the patient asks when treatment will be discontinued, I advise that a recurrence may develop if the chemical is stopped entirely. If patients insist on discontinuing, they are informed they should return immediately should any recurrence develop.

Having urged in 1962 the use of methyl phenidate intramuscularly in recalcitrant melancholia (which did not yield to MAOI therapy alone), I knew that with intramuscular use, this chemical could overcome serotonin induced hypotension temporarily, while at the same time it enhanced the antidepressant effectiveness of the MAOI. Thus, it occurred to me that it would be good if Ritalin®, which quickly overcomes serotonin induced hypotension, could at the same time facilitate or so catalyze the quick synthesis of serotonin, that remission could be almost immediate.

In the early stage of this research I saw this happen to a man and two women. The man had failed to respond to 17 different chemicals given by other physicians and had been under the care of at least four other psychiatrists in his quest for emotional improvement. In less than an hour of this treatment he was feeling "like a different person," smiling brightly, and he continued jubilant the rest of the day.

The first two patients getting the combined 5-HTP methyl phenidate potentiated regime were a 28 year old man, a reactive depressive, and a 66 year old woman in deep depression, a recurrence of manic depressive depression with marked hypertensive overlay. Both showed astonishing mood elevation as they departed after the three hour treatment.

There is a standardized pattern one observes as the Ritalin®-5-HTP is administered over a three hour period. The time involved varies with the dosage of 5-HTP given and the reactions seen when the accelerating (decarboxylating) injections of Ritalin® are given. It has become routine to inject from 10 to 15 milligrams of 5-HTP in the first dose. There may be a rise in blood pressure immediately following injection (5 to 12 millimeters or rarely 15) but then the BP drops to a point lower than that recorded before the treatment. When this occurs (actually at any point in the downside slope of the graph) Ritalin® may be given, usually intramuscularly in dosage of 5 to 12 milligrams. Then one waits to see its effect on the blood pressure. It usually rises, sometimes precipitately, and during this rise the patient may report diaphoresis (which I interpret as the result of the decarboxylation process) or just a feeling of betterment. Thereafter, the blood pressure gradually falls again to an approximation of its starting level. This may have consumed the better part of the first hour. *In paradoxical cases, however, hypotension may occur.* For this reason, it is

imperative that repeated blood pressure recordings be made from beginning to end of treatment.

Then the second 5-HTP dose can be given (12 to 15 cubic centimeters), larger than the first if no anxiety provoking developments (in the physician) occur, but equal or smaller than the first if caution dictates. The second dosage of Ritalin® depends upon and varies with the blood pressure changes that occur.

It is safer to give two or three small increments of Ritalin® of 8 or 10 milligrams intramuscularly or no more than 2 to 5 milligrams intravenously. The reason is the paradoxical sudden fall in blood pressure that may occur in rare cases, within 20 minutes after Ritalin® is given. Since many of these patients do have a large hysterical element, this factor should be kept in mind. Fright can suddenly cause either hypo- or hypertension.

It is satisfying to see disconsolate melancholiacs after only two or three hours of intravenous and parenteral treatment with hyperpotent chemicals, displaying quick return of spontaneous capacity for laughter. Elimination of persistent sobbing and a comforting disappearance of haunting perplexity are common. This is an unusually rapid recovery, on MAOI therapy, since extreme depressions require three or four weeks before remission becomes apparent on oral therapy alone. The threat of suicide is ever present until true remission is achieved.

Two of the most extreme pathologically hyperanxious women of middle age (each exhibiting severe reactive depression) have shown remarkable improvement. They smile in a natural manner not previously seen. Their apprehensiveness had been almost constantly obvious during the previous six to eight months, despite intensive MAOI therapy with supportive psychotherapy, followed ultimately by electro-convulsive therapy which became imperative. Yet, in neither case did satisfying remission occur and there was still the threat that a suicidal attempt might occur.

Following their first R-5-HTP treatment they became calm, reasonable women and both professed they have no depression and feel the best they have in years. In one case, the husband seeing his wife daily, confirmed this. The other is a widow. In this instance there is confirmatory evidence of the marked improvement over a six week period following her first R-5-HTP injection by others in frequent social contact over that period, who had not seen her for several months previously due to her self-imposed isolation because of persistent disconsolation when taking no antidepressant chemotherapy.

Two other striking cases *must* be included here—the 38-year-old wife of a professional man who has two sons, 10 and 12 years. She has been suffering with the manic depressive diathesis for a great many years, usually depressive but sometimes manic, and also occasionally mixed type. Unfortunately she mixed too many chemicals at one time (Tofranil® plus, Stelazine®, and possibly Marsilid®, each in big dosage) and during a bout of hyperpraxia was at death's door for days, some eleven years ago in a psychiatric hospital. A year ago, she was again in a deep depression and we were able to raise her spirits to a satisfactory level by Marplan®orally combined with Ritalin® decarboxylated, 5 hydroxy-tryptophan *in less than 3 weeks*. Upon returning home she wrote me: "The whole picture of my life has changed from one of dreaded apprehension to one of confidence."

The other case is a 42 year old married woman who had been treated by various doctors for a chronic depressive disorder for years. She had been given Tofranil®, Triavil® and Vivactyl® by different doctors —always an anti-depressant combined with some phenothiazine. She had never been given MAOI but did receive a course of EST a year ago. She does not believe that the 12 ECT shocks induced "real" improvement.

This is quite the opposite of her reports here in check-ups during the five months following her rather prolonged course of Ritalin® 5-HTP serotonin intensification treatments. She is doing her own house work (her husband had helped her with it, doing most of it for several years). Following remission she wrote: "I could never thank you enough for bringing me back to life again, as a human being. I shall remain indebted and grateful to you forever."

Sometimes when Ritalin® is added to 5-HTP previously administered intravenously, we observe paradoxical reactions which may be disquieting. Anyone beginning these two chemicals in staggered combinations, should give no more than 5 to 8 milligrams of 5-HTP for a first dose and wait at least 30 to 40 minutes before injecting a second dose, either large (20 mg) or small (4 to 5 milligrams).

To get the best out of Ritalin's® constructive catalyzer effects, a daily morning injection of 10 milligrams intramuscularly (or better still, 8 milligrams morning and noon) for one or two weeks immediately following the intravenous 5-HTP, has great advantage in perpetuating the patient's eudaemonia.

Thriftiness in our injections of Ritalin® proves rewarding because it takes very little to initiate the tryptophan decarboxylation process and the faster this occurs, the quicker we dissipate all (or most) of the tryptophan injected.

The primary aim of this method is acceleration of MAOI therapy. Ask each patient whether any tranquilizers are being taken, since this will counteract the effectiveness of 5-HTP. *Stop tranquilizers* and start MAOI. Give the first R-5-HTP two or three days after MAOI therapy begins.

For the occasional patient who experiences nausea during the treatment, Tigan® or Dramamine® brings quick relief. However, a cubic centimeter of pyridoxine intravenously in the 5-HTP syringe will prevent nausea during the treatment.

If the patient comes for his first R-5-HTP with a low blood pressure, give 8 to 10 cubic centimeters of Ritalin® parenterally before any 5-HTP and check blood pressure to determine whether a normal rise occurs. If so, go ahead with the dosage of 5-HTP with additional Ritalin® dosage (smaller since the test dose will continue active for three or four hours). In the paradoxical case, hypotension will be accentuated with the addition of 5-HTP and the doctor will then find he's wrestling with blood pressure levels of 80 or 70 or even non-measurable lower levels, especially in the standing determinations.

In rare instances when the hypotension from combined 5-HTP and Ritalin® has developed, Wyamine® or ACTH Gel® may induce a temporary rise in blood pressure, sufficient to allow patients to go home unaccompanied. A wise precaution is to give emergency rations of Florinef® to be taken in every-12-hour miniscule dosage for the next three days if faintness occurs. Most have a drop in blood pressure following the second 5-HTP injection. Some show improvement with no evidence of serotonin's hypotensive effect.

Kline has supplied the following specific directions for preparing the food 5-HTP for intravenous injection, which is the keystone of the treatment.

The 5-hydroxy-tryptophan (5-HTP) may be purchased from independent chemical companies such as Cyclo Chemical Corporation at 1133 Broadway, New York 10010. The 5-HTP can be prepared for intravenous injection as follows:

Weigh a sample of 5-HTP from the original bottle (store it in the dark at 32° F) using sterile equipment and sterile technic. Put it into a sterile flask. The flask containing the 5-HTP is placed in an oven at about 85° F for 30 minutes. After this, the flask is stored in the refrigerator if it is to be used within a day or two or in the freezer if it is to be stored for longer than two days. Finally, the proper amount (a milliliter per milligram of HTP) of sterile, pyrogen-free water for intravenous injection is added to the flask and the 5-HTP dissolved. No untoward effects have resulted after hundreds of injections of solutions prepared by this method.

The author had no dream that Dr. Flora's skillful thinking would be added to the ideas propounded by Kline, Loomer, Ostow, Dunlop, Crane, Sainz, Kraines, Furst, Dorfman and many others who have helped reduce markedly the use of electroshock by promoting chemotherapy.

This new utilization of a known pressor substance to activate serotonin's precursor rapidly when the 5-hydroxy-tryptophan is injected into the blood, increases in marked degree the anti-depressant effects of any MAOI. This should decrease even further deaths from suicide since it will decrease the delay period of one to four weeks heretofore necessary to bring about remission from suicidal melancholia. And the euphoric period induced, whether of two days or two months or longer assures eudaemonia again. Continued oral MAOI therapy will soon induce complete remission via R-5-HTP acceleration.

During the coadministration of 5-HTP po-

tentiated by Ritalin® we were fortunate that during a fourth recurrence of severe depression in a woman, in her 60's, a satisfactory remission of depression occurred within two days of her first R-5-HTP, with the backbone of her MAOI treatment, Eutonyl®. The remission persisted. With a woman of 45, with a severe depression, persistence of satisfactory remission has continued. Eutonyl® also served as a basis for her persistent remission, potentiated by oral Ritalin®.

To avoid possible embarrassment of the physician or possible injury to the patient, this precaution is urged: When the patient is requested to stand for upright sphygmomanography during the Ritalin®-5-HTP therapy, the doctor or nurse should be near at hand to grasp the patient should syncope occur. We have never encountered such an incident so far, but it is a fact that we have recorded 0/0 blood pressures though we have not observed syncope under those conditions. It's psychologically unwise to inform the patient he has a *nil* blood pressure at such time, for his (or her) realization might easily induce panic or actual syncope. And it would be best for both physician and patient for no injury to occur, which the physician's alertness can prevent.

6 Brookwood Drive

Defensive Driving*

Drive defensively—even if, or particularly if, the other driver is young. One-fifth of the drivers in America today are less than 25 years of age. But they are involved in one-third of all fatal auto accidents.

Defensive driving is difficult because a driver is so often unable to identify irresponsible kids (or drinkers or seniles) in time to avoid them. The driver must assume that no one else is responsible and alert.

In 1969, more than 56,500 deaths were recorded on the country's highways. The number of injured topped 4,700,000. Both figures were the highest in history. Excessive speed was the chief cause of deaths and injuries. High speed, however is not necessarily the big killer. Driving too fast for conditions is lethal, too. Ten miles an hour can be too fast on glare ice or in a "peasoup" fog. More fatal accidents occur in clear, dry weather. Poor driving conditions make the driver more alert to what's ahead or around him. Only 1.8 per cent of last year's auto fatalities occurred in fog, and only 2.1 per cent in snow. The answer to the highway problem lies in more and better driver education, tighter laws, and law enforcement.

A growing problem for many drivers is the interstate highway. Seen from an airplane, these ribbons of concrete and tar present an impressive design, but to a driver they can be a fatal trap.

Many drivers do not know what a "yield" sign really means or recognize the crucial importance of minimum and maximum speeds or the danger of blocking the outside passing lanes or know how properly to change lanes. The lack of a uniform highway sign code confuses drivers. The stranger to a highway slows down while the native zooms by, setting the stage for an accident.

*Abstracted from *Maudlin Draws Another War*, a book of accident facts released May 1970 by The Travelers Insurance Company, Hartford, Connecticut.

Special Article

The Malpractice Tide

In 1968 the AMA Board of Trustees was asked to "study and search for solutions to the problems of professional liability." A report was submitted late in 1969. Most of the material below is abstracted from that report.

In southern California, it is reported that some "high risk physicians" have had to pay $28,000 a year insurance premiums—with a $5,000 deductible clause. "There is," says the AMA report, "something unconscionable in such a state of affairs." It is anticipated that some practitioners, especially surgeons, may suffer a $3,000 to $4,000 boost. In some counties in southern California a surgeon who last year paid $1,200 must now pay $5,000 in premium for the same coverage. Even GPs who derive less than 25 per cent of their income from surgery and obstetrics have seen the escalation of a 300/900 policy from an annual premium of $1,250 to $3,000.

However, you can't blame the carrier. They have serious problems here. The report reviews a number of these. One is the small size of the "pool" of premium payers. Consider this: An automobile casualty company may insure a million drivers. The entire medical population—about 250,000 MDs is shared by only 40 carriers, an average of only 600 practitioners per company. A single judgment of, say, $120,000 does not have much impact if shared by a million drivers (that's 10 cents each policy-holder), but if that $120,000 is a malpractice judgment to be shared by only 6,000 physicians, it simply adds $20 to the premium base, and not just 10¢. Multiply that by the number of claims filed, and you can see one thing that is sky-rocketting the liability rates. Just a decade ago, about 4 per cent of the insured were being sued. Last year it was about 30 per cent!

Another headache for the carriers is the time lag between the date of filing the claim and the date of the judgment—usually several years. A doctor whose premium in 1964 was based on the 1964 dollars, may find judgment against him in 1970—but these will be the mini-sized 1970 dollars, so the company has to pay in these, though they collected from the doctor at a 1964 scale. In effect, the company has to figure out today how much the dollar will be worth in 1976!

As to the etiology of this pandemic, at least ten theories have been advanced: (1) Deterioration of the "dear friend" concept of the doctor-patient relationship. At the turn of the century a patient would have been as unlikely to sue his doctor as to sue his priest. (2) The depersonalization of much medical care. About three-fourths of all malpractice claims develop out of hospital incidents, and hospitals are usually thought of as impersonal agents. Even in the practitioner's office, a good deal of direct patient contact is through nurses, technologists, secretaries, and other paramedical personnel. (3) The growing philosophy that in any misfortune somebody has to pay. (4) Medical progress, which leads to the expectation that any ailment or injury can be successfully treated by modern methods, hence, unsuccessful treatment must spell malpractice. (5) Inflation. (6) Carelessly kept medical records. Doctors feel that they are already overburdened with records and like to short-cut all the paper work they can. (7) A stiff and unrepentent attitude on the witness stand, a reflection of sanctimony, a concept that "doctor knows best" and an indignant response to any layman's daring to challenge a physician—all clearly, but incorrectly, make a physician seem arrogant and thus arouse hostility in the jury. Everyone on the jury is, has been, or will be a patient, but no physician ever sits on a malpractice jury. Thus the jurors' identifications are with the plaintiff, not with the physician. (8) The image of the physician as a successful business man. Many of the nonclinical medical journals and newspapers or newsletters carry articles on investments and stock prices. Since laymen have wide access to these pub-

lications, such items emphasize the "successful businessman concept" of the physician. (9) The general assumption that the doctor is insured anyway, so it really won't cost him anything if the patient can make several thousand dollars out of his illness. (10) The habit of claimants' attorneys of suing everyone who had any part in the treatment—the surgeon, the technician, the nurse, the assistant, the anesthetist, and sometimes the janitor who cleaned the floor. This means that the many defendants point the finger at each other, each saying it is the other one's fault.

One side effect of this is that the suit-conscious physician tries to protect himself by ordering every possible (and some impossible) laboratory or x-ray procedures, by giving only "tried and true" medications and treatment regimes, and by avoiding anything innovative or experimental. All progress in medicine will grind to a halt if no one has the courage to be the first to try something new. But with the malpractice lawyer breathing down your neck, why run the risk? It's not only the cost of the judgment, but the constant fear that maybe the company will not renew your insurance next year and then what will you do?

Treatment of this pandemic has been the subject of much thinking and writing. Many of the suggestions are valuable but vague generalizations, such as, be nice to all your patients, keep good records, and don't do anything that can't be supported by the literature or by a consultant. A number of other suggestions are reviewed in this report, many of which would require legislation. Here are some of the proposed remedies.

1. Set rates on a regional (multi-state) basis so that there will be a larger pool of insurables, and so that the low risk areas could better balance the high-risk parts of the regions.

2. Abolish or limit application of *res ipsa loquitur*. Under this doctrine, if a procedure is usually safe, but if it resulted in damage in this case, the doctor has to prove that he was *not* negligent. In civil suits, generally, the burden of proof is on the patient; but in malpractice, it is too often on the physician. Perhaps the legislature might be urged to enact a statute that would always impose on the plaintiff the burden of proving that the doctor was negligent instead of just assuming negligence from bad results.

3. Use arbitrators instead of slow and expensive jury trials.

4. When several defendants are named jointly, let them get together and cooperatively work out a defense strategy instead of having each blame the other.

5. Set up screening panels, including representatives of medical societies and bar associations, with the expectation that no suit would be brought if this panel decided that the doctor was not negligent. Obviously this would be acceptable to the plaintiffs only if the medical societies were willing to provide expert witnesses when the doctor indeed *was* negligent.

6. Allow the insurance carrier to advance payment to a sick or injured patient to tide him over the years before the trial starts, with the understanding that (a) this does not imply negligence, and (b) if a judgment is rendered, the advance payments will be deducted from it.

7. Clarify the Statute of Limitations, so that the time period begins with the last date of the alleged negligent act, and not when the patient discovers that he might have a case.

8. Refuse to charter any company for doing insurance business in the state unless it agrees also to write malpractice insurance for state-licensed physicians at reasonable rates.

9. Remove the whole concept of negligence from the professional liability field much as it has been deleted from the field of workmen's compensation. If your cleaning woman fell off a chair while she was dusting your wall-hanging diploma, she doesn't have to

prove your were negligent. She collects workmen's compensation and no one points a finger at you and calls you negligent. The mal in "malpractice" has a malignant sound. Why not "patient compensation" analogous to "workmen's compensation," with a fixed dollar or percentage amount scheduled for each kind of disability and no problem of proving that any one was negligent?

10. Let a patient file a bond before he starts a suit, so that if the claim is frivolous, malicious, spiteful, or without any merit at all, the plaintiff would forfeit the bond.

Some doctors look to the American Medical Association for help here. Actually, any operational role would be difficult for a nationwide organization since these problems are governed by state law and state practices. Facilities of the AMA are available for the organizations of seminars and workshops on the subject. The federal government has lately shown an interest in the problem, because it is underwriting a substantial part of the costs of health care. Costs attributable to malpractice litigation are ingredients in cost of medical care. The federal government has indeed established an office for a "Special Assistant for Malpractice Research" and attached it to the Department of Health, Education, and Welfare. If, as this suggests, the problem is going to move into the national field, there may be increasing opportunity for AMA intervention. At it June 1970 session, the AMA House of Delegates approved a Board of Trustees' report which stated: ". . . the best way to provide assurance" (that physicians have essential liability insurance so as to provide medical care to the public) "is on a collective, rather than an individual basis, under programs jointly sponsored by the AMA and the respective state medical association. Minimum standards are being developed" and the Professional Liability Committee of the Board "is seeking with the insurance industry a means of instituting . . . insurance programs under such joint sponsorship."

It is sad when a doctor must view every patient, new or old, as a potential adversary.

Council and Committee Chairmen 1970-1971

Alcoholism
George Rogers, M.D., Camden
Annual Meeting
James A. Rogers, M.D., Paterson
Cancer Control
John L. Olpp, M.D., Englewood
Child Health
William J. Farley, M.D., Nutley
Conservation of Vision, Hearing, and Speech
Frank B. Vanderbeek, M.D., Paterson
Constitution and Bylaws
Lorrimer Armstrong, M.D., Westfield
Credentials
Louis F. Albright, M.D., Spring Lake
Drug Abuse
Henry A. Davidson, M.D., East Orange
Emergency Medical Care
Jack R. Karel, M.D., Hillside
Emotional Disorders of Childhood and Adolescence
Eugene V. Resnick, M.D., Paramus
Environmental Health
Roslyn Barbash, M.D., Teaneck
Finance and Budget
Thomas C. DeCecio, M.D., Cliffside Park
Honorary Membership
Ralph M. L. Buchanan, M.D., Phillipsburg
Judicial
John S. Madara, M.D., Salem
Legislation
Jesse McCall, M.D., Newton
Maternal and Infant Welfare
John D. Preece, M.D., Trenton
Medical Defense and Insurance
William J. D'Elia, M.D., Neptune City
Medical Education
James A. Rogers, M.D., East Orange
Medical Services
Louis K. Collins, M.D., Glassboro
Medical Student Loan Fund
Frank J. Hughes, M.D., Gloucester
Medicine and Religion
Luke A. Mulligan, M.D., Leonia
Mental Health
Robert S. Garber, M.D., Belle Mead
Mental Retardation
Miles E. Drake, M.D., Vineland
Occupational Health, Workmen's Comp. & Rehab.
Joseph A. Lepree, M.D., Elizabeth
Project Hope/Vietnam
Thomas C. DeCecio, M.D., Cliffside Park
Publication
George B. Sharbaugh, M.D., Trenton
Public Health
Robert G. Salasin, M.D., North Wildwood
Public Relations
John J. Crosby, Jr., M.D., Jersey City
Retirement Plan for Physicians
Nicholas E. Marchione, M.D., Vineland
Seizures
J. Lloyd Morrow, M.D., Passaic
Traffic Safety
Irwin S. Smith, M.D., Willingboro
Trustees
Thomas C. DeCecio, M.D., Cliffside Park
Woman's Auxiliary
William J. Roe, M.D., Englewood

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

Two regular meetings of the Board of Trustees were held during the 1970 Annual Meeting in Atlantic City. Detailed minutes of these meetings are on file with the secretary of your component society. Below is a compilation of significant actions.

May 15, 1970

Steering Committee on Medical Advances and Planning . . . Named Nicholas A. Bertha, M.D. and James A. Rogers, M.D. as MSNJ representatives on a proposed statewide Steering Committee on Medical Advances and Planning, which would be charged with organizing a "Department on Medical Advances" directed to stimulating the interest of physicians, coordinating existing activities, and eliminating duplications in program offerings. (There would be two representatives from the Directors of Medical Education, and two from each of the medical schools.)

Statewide Emergency Medical Care Exercise . . . Approved (with no financial involvement) cosponsorship, with the New Jersey Hospital Association and the Division of Emergency Health Services, U.S. Public Health Service of an "emergency medical care exercise" in May, 1971, to include participation of every general and medical-surgical hospital in New Jersey.

Committee on Publication . . . Approved the following recommendation from the Committee on Publication:

That the Board of Trustees approve the interspersal of advertising throughout *The Journal* with the clear understanding that no scientific article (nor any other section of the text) will share the page with an advertisement, and that the continuity of a scientific article, editorial, or news item will not be interrupted.

Committee on Child Health . . . Approved the following recommendations from the Committee on Child Health (previously approved by the Council on Public Health):

1. That the revised guide (for perinatal study conferences) be distributed to the hospitals in New Jersey and their departments of obstetrics and pediatrics, for their information and assistance in the development of perinatal study conferences.

2. That MSNJ record itself as urging that all school physicians accept responsibility and leadership by becoming actively involved in the administration of school health services in their respective communities, thereby *promoting* maximum health services for all school children in the State of New Jersey.

Note: The above recommendation was amended by the Board by inserting the word "promoting" indicated by italics.

3. That MSNJ direct an appeal to the Governor, as well as to Commissioner Marburger, of the State Department of Education, requesting the creation of an Advisory Council on School Health, which shall be composed of qualified physicians and health professionals, including nurses, educators—particularly in health and physical education—and other interested persons, including parents, to assist the office of Health, Safety, and Physical Education to explore, develop, and service all areas of school health.

4. That MSNJ urge and encourage all of its members to participate actively in the development of preventive programs on drug abuse in their communities and become knowledgeable on all aspects of this sociological-medical crisis in order to make a meaningful contribution to the solution of this major problem.

5. That sufficient copies of "Respect for Drugs," issued by the U. S. Government Printing Office, be obtained for distribution to the Committee.

Report of AMA Committee on Planning and Development . . . Approved our special committee's recommendations to review the report of the AMA Committee on Planning and Development and directed that annotated copies of the AMA Report in its entirety, (indicating the positions taken by MSNJ) be prepared for the use of MSNJ's Delegates and Alternates at the AMA Convention, June 1970.

Physicians' Retirement Plan . . . Accepted the report of Legal Counsel that his review of Retirement Plan Trust A and Trust B, formulated by Prudential, revealed that the plans are in good form and content.

Resolution in Support of A-1059 . . . Endorsed the preparation by the Executive Director and Dr. Albright of a suitable resolution to be presented to the 1970 House of Delegates to record MSNJ's approval of A-1059.

Note: Subsequently Resolution #29 was presented to the House, a substitute resolution encompassing the substance of Resolutions #17, #29 and #32 was offered by Reference Committee "E" and adopted by the House.

Correspondence . . . Received a communication from the Cumberland County Medical Society requesting a uniform fee for all doctors in all localities of the state for Medicare/ Medicaid patients.

. . . Referred a communication from the New Jersey Obstetrical and Gynecological Society requesting that MSNJ effect changes in malpractice legislation to the Joint Committee of the Council on Legislation and the Committee on Medical Defense and Insurance.

. . . Directed that memorial resolutions from the Cumberland County Medical Society honoring James Knowles, M.D. and Paul Lang, M.D. be adopted.

Acknowledgments . . . Received and filed the following communications:

1. From Governor Cahill announcing reappointment of Anthony J. Balsamo, M.D. to the State Board of Medical Examiners.

2. From District Governor of Lions Club agreeing to become one of the agencies officially cooperating with MSNJ in its Eye Health Screening Program.

3. From Executive Director of Catholic Welfare Bureau indicating that nothing in the Bureau's policies should be considered as discriminatory against general practitioners and that this will be made clear to their clients.

Retiring Members of the Board . . . Gave a rising vote of appreciation to John F. Kustrup, M.D. and Louis F. Albright, M.D. on their retirement from the Board.

May 20, 1970

Introduction of New Members . . . Welcomed new member from the 4th District, Harold L. Colburn, Jr., M.D.

. . . Announced that Louis F. Albright, M.D. had been elected Secretary of the Society; that Charles L. Cunniff, M.D. had been elected to fill the unexpired term from the 2nd District of Matthew E. Boylan, M.D., just elected to 2nd Vice President; and that Francis E. Benz, M.D. (1st District) and A. Guy Campo, M.D. (5th District) had been re-elected to the Board.

Reorganization of Board . . . Elected Thomas C. DeCecio, M.D. as Chairman of the Board for 1970-1971; elected George E. Barbour, M.D. as Secretary of the Board for 1970-1971; agreed to meet regularly at 10:45 a.m. on the third Sunday of each month in the Executive Offices (meetings subject to cancellation should the agenda prove insufficient); re-elected Thomas C. DeCecio, M.D. to succeed himself as Board member on the Committee on Finance and Budget.

Staff . . . Reappointed for 1970-1971, at the salaries set forth in the adopted budget, all salaried personnel not under individual contract.

. . . Commended the staff and recorded its appreciation for the success of the 1970 Annual Meeting.

Nominating Committee . . . Concurred with the directive of the House of Delegates that the proposed amendment to Chapter V, Section 1, paragraph (d) of the Bylaws — to change the time of meeting of the Nominating Committee—be referred to the Standing Committee on Revision of Constitution and Bylaws.

Automated Bookkeeping and Billing System . . . Directed that a committee, composed of the Treasurer, the Secretary, the Chairman of the Finance and Budget Committee, and the Business Manager, be established to investigate the procedures necessary to implement a

statewide automated bookkeeping, accounting, and billing system, in accordance with Resolution #4 adopted by the House of Delegates.

Physicians' Welfare Fund . . . Authorized the appointment by the President of a five-man committee (one member from each judicial district) to investigate a Reference Committee "B" suggestion that such a committee be appointed to define the terms of administration of a physicians' welfare fund, to be financed by an annual dollar per capita taken from surplus.

Note: Resolution #16 dealing with this subject had been disapproved but the Reference Committee agreed with its intent.

National Academy of Health Professions for Research and Policy . . . Directed that Resolution #6—urging that any structure considered for a "National Academy of Health Professions" include representatives of hospital chaplains—be referred to the AMA Delegates for necessary action.

Interns' and Residents' Power to Sign Legal Documents . . . Referred to the State Board of Medical Examiners to obtain a formal opinion (as recommended by Reference Committee "E" and approved by the House) as to whether the privilege outlined in a previous opinion, which declared that prescriptions signed by interns and residents of the Martland Medical Center in Newark may be legally filled in retail pharmacies of the area, may extend to all New Jersey hospitals.

Immunity for Physicians Volunteering in State Medical Programs . . . Agreed with the action of the House and referred Resolution #7—to seek enactment of legislation which would provide licensed physicians and their professional societies with immunity from litigation which may raise from rendering professional services voluntarily in any New Jersey State Department of Health programs—to the President for implementation.

Legislative Approach to Malpractice . . . Directed that the contents of Resolution #9 (approved in principle by the House)—listing fourteen areas of consideration for reducing the incidence of malpractice suits—be referred to the Joint Committee of the Council on Legislation and the Committee on Medical Defense and Insurance.

Opposition to Legalization of Marijuana . . . Directed that a news release be prepared indicating the position of MSNJ in opposition to the legalization of marijuana as outlined in Resolution #10; and further directed that this item be referred to the AMA Delegates.

Medicare Billing Forms . . . Directed that Resolution #12—favoring a change in the Medicare form to include the amount due the physician by the patient—be referred to the Liaison Committee with Medicare.

Medical Education in New Jersey . . . Directed that a copy of substitute resolution for Resolutions #17, #29, and #32—in support of A-1059 and the Governor's message on medical education—be hand-delivered to the Governor.

Compensation Under Medicaid . . . Agreed that the Board should direct a letter to Commissioner McCorkle of the Department of Institutions and Agencies, with a copy to the Director of the Division of Medical Assistance and Health Services, concerning the content of Resolution #19—that the Medicaid Commission "make available to a practicing physician, upon request, his own fee profiles and the allowances to him assigned by the Carrier, together with an explanation of the mechanism by which the figures are arrived at" and "put in print the criteria and standards to be used by its consultants with respect to authorizations for medications and services requiring the prior permission of the Commission."

Criteria For Reviewing Physicians' Services . . . Directed that the Society's stand as stated in Resolution #20—against the practice of the fiscal intermediaries for Medicare reviewing services of physicians for evidence of overutilization, abuse, and fraud, and directing the results of such review to patients with the

inference that the services were not good medical practice—be communicated to the General Manager of Prudential Insurance Company with a copy to the Company's Medical Director of Governmental Insurance Programs.

Medicaid and the Rehabilitation Commission . . . Referred Resolution #21—to study past guidelines and make revisions to up-date the relationship between Medicaid and the New Jersey Rehabilitation Commission to effect uniformity throughout the State—to the Committee on Occupational Health, Workmen's Compensation, and Rehabilitation for action.

Payment Under Title XIX for Physicians' Services in Out-Patient Departments . . . Referred to the Executive Assistant for clarification of intent of Title XIX concerning payment for physicians' services in out-patient departments, prior to attempting implementation of Resolution #22—to modify regulations under Title XIX to allow a physician serving in the out-patient department to file a claim for the professional component portion of the out-patient fee, or to urge hospitals to enter into contracts with physicians who serve in such departments.

Glass Door Hazards . . . Directed that a communication go to the Governor concerning content of Resolution #23—to introduce appropriate legislation to insure that only safety materials be used in all new glass doors.

Drug Abuse Registry . . . Referred to the Council on Legislation Resolution #30—urging legislation to establish a confidential registry of such addicts and drug abusers, and to make narcotic addiction a reportable illness.

Internships . . . Referred to the AMA Delegates Resolution #31—in favor of continuing internships in community hospitals even though no residency programs are offered, and disapproving a recommendation of the AMA Council on Medical Education that a cutoff date be set up five years hence whereby a hospital having only an internship and no residency program would no longer be approved for internships.

Physicians' Exclusive Right to Render Medical Judgments . . . Referred to the Council on Medical Services and the Council on Legislation action on Resolution #33—to ensure that medical decision remains the domain of the physician and that policy decision be reached only with full consultation with qualified treating physicians.

Department of Mental Health and Mental Retardation . . . Agreed that a letter be addressed to the Governor requesting the establishment of a separate Department of Mental Health and Mental Retardation, as called for in Resolution #13.

Air Pollution . . . Directed that a suitable resolution be drawn up for presentation at the AMA Convention in June as outlined in Resolution #14—that the AMA initiate a continuing campaign through the public media alerting the American people to the health hazards of air pollution and to the urgent need for research and effective control measures.

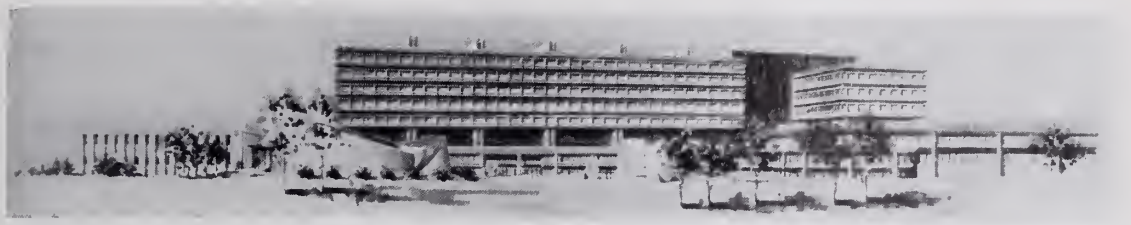
Medicaid Peer Review Committee . . . Designated the following MSNJ members to serve on the Medicaid Peer Review Committee, as requested by the Deputy Director, NJI&A:

1st District—Nicholas A. Bertha, M.D. (Morris)
2nd District—Ambrose P. Boyle, Jr., M.D. (Bergen)
3rd District—David Eckstein, M.D., (Mercer)
4th District—Emanuel Abraham, M.D. (Monmouth)
5th District—Mario Pastore, M.D. (Cumberland)

Medical Student Loan . . . Directed that the Committee on Medical Student Loan arrange a dinner meeting with the deans of the two New Jersey medical schools to acquaint them with the revised requirements for participation in the Medical Student Loan Fund, effective June 1, 1970.

Unified Board of Trustees for Medical Schools . . . Recommended that the name of Nicholas A. Bertha, M.D., be presented to the Governor to serve on the unified Board of Trustees for state controlled medical schools after the necessary enabling legislation has been enacted.

(A-1059 subsequently enacted into law and Dr. Bertha's name was forwarded to the Governor.)



News From NJCMD

As we are a medical-dental college with an integrated curriculum, we often hear comments viewing dentistry as a health specialty along with the other major specialties. This pleases the dentist, and while it may amuse or even annoy some physicians, it is undoubtedly a sign of the times. It is a healthy sign, if you'll pardon the pun.

Both disciplines have important contributions to make each to the other. Your college tries to create a cooperative atmosphere. The dental practitioner today must take his place as part of a highly trained, cooperating team of health specialists working together to provide health care. In urban health care delivery, in surgery involving the region of the head and neck, and in reconstructive and plastic surgery major cooperation (physician and dentist) has been the rule for some time.

Recognition of dentistry as a specialty of medical care points up one of the hazards of the proliferation of specialties and subspecialties: lack of knowledge and interest on the part of some practitioners in a particular region of the body which may have some bearing on their practice, while not directly a part of their specialty.

With respect to the oral cavity, the dentist, better than any M.D., knows about the area and the things that can go wrong, or even be right there. Yet many of the major medical problems which *can* develop in the region are often overlooked, and this is true in the dentist's chair as well as the physician's office.

"All kinds of potential problems can be caught and corrected, provided the dentist learns to look at the teeth last." That's a quote from Professor Frank M. Lapeyrolerie, D.D.S., F.A.C.D., Chairman of the Department of Oral Surgery, Anesthesiology and Hospital Dental Services at NJCMD and Martland Hospital. And it sums up one of his major concerns, which he tries to impart to medical and dental students alike. He says, "The dentist often becomes mesmerized by caries, loss of teeth, and periodontitis."

"On the other hand, about the only thing the M.D. sees is the tonsils!" Lapeyrolerie muses. "The physician might see the tongue, but in any case he looks right past the teeth and most of the oral cavity." Both errors, he stresses, are dangerous and overlook the welfare of the patient, which should be of prime concern to the practitioner, regardless of the initials following his name.

"Cancer of the oral cavity," says Lapeyrolerie, "is perhaps being seen, but is often overlooked. Despite recent advances in the treatment of cancer, early detection still remains the single most important hope, as it has always been."

"For example," he says, "the five-year cure rate of cancer of the oral cavity is around 32 per cent. If a malignancy is discovered before it reaches one centimeter in diameter, the five-year cure rate goes up to 57 per cent. But, cancer usually begins as a benign, innocuous-looking lesion. It doesn't become painful, and thus is not discovered by the patient, until it is far advanced. By that time there is a low possibility of any cure. Here, both dentist and physician are guilty."

"The M.D.," says Lapeyrolerie, "should also be interested in looking at teeth, if he is interested in his patient. It doesn't take a sophisticated person to look at a tooth and know it has a hole in it!"

One hears women say they would rather bear a baby than have a toothache, says Lapeyrolerie, and he points out that the pain of a toothache can be excruciating and longterm. "The comparison to childbirth is not entirely spurious," he says. A toothache measures about 6 Dols (unit for measuring pain) while childbirth rates 7 to 8 Dols, which indicates the similarity, at least in depth of feeling."

Medical symptoms and complications originating from dental problems can be serious, points out Dr. Lapeyrolerie. "Acute abscesses which develop as a result of a tooth being decayed can be very severe. When they involve the floor of the mouth they often can cause respiratory difficulties. An abscess of the oral cavity may involve the brain, or descend to involve the chest. We have seen abscesses of dental origin that have gone as far down as the mediastinum.

Lapeyrolerie feels the physician should be concerned with missing teeth as well. "This can lead to migration of the remaining teeth, which contributes to malocclusion which leads to imbalance of the muscles of mastication and abnormal arrangement of the head of the condyle in the glenoid fossa. The patient may complain of dull, diffuse radiating pains of the muscles in the face and head; traumatic pain in the joints; and headaches.

"The M.D. should also be interested in the number of filled teeth the patient has. If numerous, the patient is probably one who has had numerous cavities and should be reminded of the necessity to have frequent checkups because of the high probability of the recurrence of caries. The patient should be very careful about consumption of refined sugars, which readily break down to acid in the mouth. The acidogenic theory is one which has been proposed to explain the cause of caries.

"Discourage your patients, particularly children, from eating habits that would lead to a sustained, prolonged concentration of simple sugars in the mouth, for example sucking on hard candy. This may last for hours, which increases the chance of formation of dangerous acids. It's far better, to eat a soft candy such as a chocolate bar, which is gone quickly. Hard candies are more deleterious than the soft, as they lead to prolonged presence of sugars in the mouth. Preferably, encourage the patients to eat potato chips and pretzels!" The physician should observe the presence or absence of calculus on the teeth, as well as materia alba. A prevalence of calculus can lead to gingivitis and eventually periodontitis. Materia alba indicates poor brushing technic or the absence of brushing.

"More teeth are lost in this country," stresses Dr. Lapeyrolerie, "because of periodontitis than because of cavities. A rule of thumb is that before age 25 most teeth are lost due to cavities; after 25 most are lost because of periodontitis or diseased gums."

"There can be manifestations of systemic diseases in the mouth," continues Lapeyrolerie, "and physicians and dentists alike should be concerned with this. Some are characterized by atrophic changes of the mucosa and gingiva; abnormal pigmentation of the mucosa and gingiva; 'baldness' or smoothness of the tongue; hyperplastic papillae (coating) of the tongue; cracking of the lips; and reduction in salivary flow. These can indicate underlying disease."

"The physician should ask his patient to open and close his mouth to see whether there is a deviation of the jaw, to the right or left. Such deviations," says Dr. Lapeyrolerie, "can be indicative of major pathology requiring the immediate attention of a dentist. This doesn't require a dental orientation. Rather, it implies that the physician has an interest in his patient, and a pair of discerning eyes. In dental school, we teach students to look at the teeth *last*. We want the dentist to look at the patient from the top of his head down to the toes. *Then* the oral cavity. Examine the mucosa, the gingiva and the pharynx, realizing that caries and periodontitis never constitute a threat to anybody's life. But cancer, or oral manifestation of systemic diseases if undetected, can be fatal.

"This is repeated all through the student's schooling at NJCMD. It might be a good thing if every doctor would keep it in mind, regardless of his schooling, training, or specialty."

Just as the dental students at NJCMD are given a broad background in the general medical state of the human body, we hope the medical students will take note of Dr. Lapeyrolerie's teachings and philosophy.

Every year, in the NJCMD course in physical diagnosis, a dentist is invited to address the medical students as guest lecturer, relative to diseases of the oral cavity. Dental students receive a course in medical background taught by physicians, to provide the same broad understanding as the medical students receive through coming in contact with dental thinking.

As you read this article on the thoughts of a prominent dentist regarding medicine, we are also preparing a discussion on the course in medicine taught to dental students. This article will be published in the State Dental Journal. We invite your comments on this program of cross-germination of ideas and thoughts.

Behind The Drug Scene

(This column is prepared by Stanley Einstein, Ph.D., Coordinator, Drug Abuse Project, Martland Hospital Unit, NJCMD, Newark, and Executive Director, Institute for the Study of Drug Addiction, New York City.)

Traditionally, the drug problem has been looked at from three perspectives:

1. Drug use patterns (type, frequency, amount).

2. Characteristics of users (age, sex, race, ethnicity, religion, marital status, economic level, and social class).

3. Behavior of users (physical and psychological functions and dysfunctions, conventional and deviant social involvement).

The obvious conclusion to be drawn from this is that drug abuse results from the combination of certain drugs and certain people and that this leads to predictable consequences. This is not the case.

Drug abuse is basically a community problem. It is but one facet or symptom of the contemporary trend of various people turning to *things* (drugs being one such *thing*) rather than to people as they attempt to adapt to the stresses and strains of contemporary living. If drug abuse, or "progress through chemistry," is to be effectively and meaningfully diminished, we must become aware of the other facets that play a significant role. These factors include:

1. The state of scientific knowledge as it relates to drugs and drug users. What are our theories about the actions of the drugs and the etiology of abuse?

2. Treatment programs as they relate to:

a. Evaluation methods and procedures
b. Goal setting systems
c. Treatment modalities
d. Policies and procedures
e. Follow-up systems
f. Early case finding

3. Public policy as it effects laws, politics, and procedures.

4. Treatment agent and community attitudes and values as they effect stereotypes of drug users, and stereotypes of the drugs.

5. Economics in terms of the legal and illegal component of the problem.

6. Education as it reinforces or inhibits alternatives to living.

7. Religion and philosophy as reinforcers or inhibitors of social rituals.

8. Mass media as catalysts for "people oriented" patterns of living.

Given that at any point in time, anywhere in this universe, people experience only a limited number of problems and ways of living, for which there are only a limited number of solutions and adaptive responses, we must become more cognizant of the ingredients that make up our contemporary drug scene and the meanings attributed to each of them.

This column will focus on specific factors and issues that are of concern to us. Your comments and suggestions would be appreciated.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Disease during the months of May and June.

	1970 May	1969 May
Aseptic meningitis	10	10
Primary encephalitis	1	1
Post-infectious encephalitis	0	0
Hepatitis: Total	272	178
Infectious	226	144
Serum	46	34
Malaria: Total	7	13
Military	6	11
Civilian	1	2
Meningococcal meningitis	10	17
Mumps	314	314
German measles	151	131
Measles	255	128
Salmonella	54	61
Shigella	15	21

	1970 June	1969 June
Aseptic meningitis	9	13
Primary encephalitis	2	2
Post-infectious encephalitis	0	0
Hepatitis: Total	295	170
Infectious	224	127
Serum	71	43
Malaria: Total	6	11
Military	3	11
Civilian	3	0
Meningococcal meningitis	3	7
Mumps	258	212
German measles	84	42
Measles	140	174
Salmonella	56	50
Shigella	30	39

Meningococcal Infections—1969

A total of 191 meningococcal infections were reported to the New Jersey State Department of Health throughout 1969. New Jersey residents accounted for 104 infections. Military personnel and their dependents (treated in armed forces facilities) accounted for 87. The 191 meningococcal infections included 133 cases of meningitis and 58 of meningococcemia. The over-all figure represents a decline of 83 cases (30 per cent) from the 274 cases reported in 1968. This reduction occurred in the military population which was responsible for 198 meningococcal infections in 1968. Among the civilian population, however, there was an increase of 28 meningococcal infections in 1969 compared to 1968.

Nineteen of the 21 counties reported meningococcal infections. No cases were from State institutions. Although Essex and Camden Counties reported the largest numbers of cases, 18 and 13 respectively, the highest attack rates were observed in Warren and Ocean Counties, where the rates were 4 and 3.5 per 100,000 of population.

The largest number of cases in the civilian population (43, representing 41.4 per cent of the total) and highest attack rates occurred among children under 5 years of age. After a secondary peak among the 15 to 19 year age group, the attack rate decreased with increasing age. This is in contrast to the military population where virtually all cases occurred in the 15 to 24 year age groups.

Seventy per cent of the meningococcal infections occurred between January and May. This distribution during winter and spring months was similar to the seasonal incidence observed during 1967 and 1968. The peak was observed in February for both the civilian and military populations, and accounted for 18.8 per cent of the total cases. This is similar to the peak activity recorded in March, 1968.

The 133 cases of meningococcal meningitis represented a decline of 27 cases from 1968, but was nine above the 1967 figure. Thirty-four cases, (25 per cent of the total) were reported from military installations, whereas this group accounted for 55 per cent of cases in 1968. Fifty-eight cases of meningococcemia were reported during 1969, 53 of which were among military personnel.

Ninety-five meningococcal isolates were tested for sulfadiazine sensitivity during 1969. Among these, 89.5 per cent were resistant to concentrations of sulfadiazine of 1.0 milligrams per cent and higher. There were 81 group C isolates, 74 (91.4 per cent) of which were resistant to sulfadiazine.

Thirteen deaths occurred among the 191 meningococcal infections, a case fatality rate of 6.8 per cent. Significantly, no clusters of cases were reported during 1969.

Syphilis

In April 1970, fifty-nine cases of infectious syphilis were reported to the State Health Department from Essex County. Fifty-five or eighty-five per cent of these cases were diagnosed and reported in Newark. The number of cases reported in April represents a 100 per cent increase over the preceding month and is *the highest number of infectious syphilis cases reported in one month* in Essex County since 1964.

Persons volunteering for medical attention, either to a public clinic or to a private physician's office accounted for 49 per cent of the cases reported. Twenty-three per cent of the cases were diagnosed and reported as a result of the Reactor Follow-up Program. The remaining 28 per cent were brought to medical attention through the findings of the epidemiology staff, applied to known cases of infectious syphilis.

Males with infectious syphilis outnumbered females seven to five. The youngest patient was fourteen; the oldest, fifty-nine.

In Newark the cases were distributed through all parts of the city. No one area had an abundance of related cases indicating a localized neighborhood epidemic. The cases reported from the surrounding communities (East Orange, Irvington and Montclair, for example) were mostly related to cases occurring outside of their area.

The staff of the Newark Venereal Disease Clinic interviewed all the cases reported, whether from a public or a private source. Each physician who had diagnosed one of the eighteen privately reported cases gave his permission for one of the field staff to interview his patient. Each patient was re-interviewed at least once, some as many as five times, and by different interviewers, to determine the source and possible spread of his infection.

Each epidemiologic interview produced an average of two sexual contacts to an infectious case within the past six months. All of those contacts who had been exposed to an infectious lesion (and who were clinically and serologically negative at the time of first examinaton) received the recommended prophylactic treatment, thus reducing the possible incubation and spread of syphilis.

For every two cases of infectious syphilis reported during April, the epidemiologic staff identified the source of one. Failure to identify the source of an infectious case of syphilis will certainly contribute to further incidence. During April, this failure in Essex County was due mainly to two factors; first, the patient's reluctance to involve his sexual partners in the epidemiologic process; and second, the patient's lack of knowledge about his sexual partners. This was especially true concerning the eight male homosexuals cases interviewed —they either did not know their sexual partners or they were completely unwilling to inform their partners of the need for quick medical attention. To combat these obstacles the field staff is concentrating on a thorough analysis of their interviewing procedures, hopefully leading to more potent and meaningful motivations that will encourage a patient to aid in halting the spread of syphilis. The staff is also continuing to use and strengthen the cluster process, whereby people who are not direct sex partners to reported cases, (but who are described in an interview as having symptoms suggestive of syphilis or as being treated for syphilis) are brought to medical or investigative attention.

The rise in incidence of infectious syphilis in Essex County could be attributed to many factors—a true incidence rise; a better community knowledge of the symptoms of syphilis; the private physician's skill in diagnosis and his willingness to report his infectious cases to the Health Department; or the diligence of the staff in interviewing and investigating.

It is the aim of the Venereal Disease Program to strengthen and expand all possibilities in order to have a valid picture of true incidence, and to work with all possible speed in stemming the spread of infectious syphilis.

Medical Education

The following is an editorial which appeared in the May 1970 issue of the Burlington County Medical Society Newsletter, Harold L. Colburn, Jr., M.D., Editor.

The shortage of physicians is presently acute and it will become greater in the future.

The present measures to educate more physicians are to expand and to erect more medical schools. Building new schools increases the cost of medical education and is time consuming. Might it not be more feasible to restudy present methods of medical education and develop a new system?

Let us consider what we desire to achieve in the education of a physician. First, he should be an individual who is able to reason and communicate. Second, he should be well grounded in the basic clinical sciences; not an expert, but one who knows the language of each of the sciences and how to interpret the findings. Third, he should be trained in clinical medicine to observe, record, and serve the patient who consults him. Beyond this, he must have a basic intellectual honesty which completely inhibits him from fooling himself or his patient. If he can learn to like people with all their weaknesses and not to place excessive value on his services, he will become the ideal physician.

Now to accomplish the first requirement. Might it not be possible to change the curriculum of the high school and adapt it to the need of the student who is planning to enter a profession and reduce the time to three instead of four years? This student will be going to a liberal arts college. The three essentials for his admission are the ability to reason, the ability to communicate, and the ability to be perceptive in his environment. Training in mathematics is probably the best exposure to reasoning. Training in English, in our country, is the best way to learn to communicate. To become perceptive in his environment, he should learn to read a newspaper, and to study the history, topography, flora and fauna of his surroundings. The audio-visual-tutorial system of teaching should be adopted. This permits the student to learn at his own speed and involves him in the learning process rather than being spoonfed. It also eliminates the difficulties experienced by students who learn by either auditory or visual reception.

Presently, admission to a medical school requires four years of college training. The courses required are a year of physics and biology, two years of chemistry, and a foreign language, as well as liberal arts courses. In most colleges it is presently impossible to complete these in two years. Many colleges have so-called premedical courses. The student entrapped into this course becomes an academic orphan because each faculty member is interested in his particular discipline and feels that it is time wasted to bother with the student who is going on to a professional school. Also he knows little about the requirements for the study of medicine. The student should learn the language of the science so that he can later interpret and integrate it with his medical studies. This also applies to the pre-clinical sciences that he takes in medical school. However, here it is understood that each student is not going to be an anatomist, a physiologist, or a pathologist. The pre-clinical science teachers know that these disciplines will amalgamate in the student's mind and enable him to interpret the phenomena he later finds in patients.

So might it be possible to establish in each medical school a four year course combining the two years of premedical sciences and grant a Bachelors Degree in Medical Sciences? One of the present problems in medicine is that the student feels that on admission to medical school he is entering the world of graduate study. He becomes disillusioned and sometimes discouraged when he realizes that he is still in an undergraduate school, taking courses, competing for marks, and at the end receiving a degree that is equivalent to a Bachelors Degree. If the medical schools do not set up such a curriculum, they should have some voice in the colleges that train pre-medical students. Another possibility would be to have the college adopt such a curriculum. The advisors of

these students should have medical training and be able to indicate to the college faculty the course work necessary for the study of medicine.

On the satisfactory completion of the two years of college and two years of pre-clinical sciences, the student should receive the degree of Bachleor of Medical Sciences. Now he has the opportunity to continue graduate study in one of the pre-clinical sciences for a Masters Degree or a Doctorate. One of the great needs is for teachers in the pre-clinical sciences. This system of education would help to fill it.

The other choice that the graduate has is to proceed into clinical medicine. Here the teaching should be on a graduate level and can best be accomplished by an association of the medical school's teaching hospital with satellite teaching hospitals. These hospitals should have staff members who are interested in and skillful in teaching. A small full-time faculty would be needed too. It must be remembered that the practice of medicine is an art. It can best be learned by doing, under proper supervision. The student should be stimulated and required to find things out for himself instead of using the present spoon feeding and regurgitating methods. During the first two years of this program, the student should function as a junior and senior clinical clerk and the third year as an intern. At the satisfactory completion of this period and following the production and defense of a dissertation, he should receive the degree of Doctor in the Art of Medicine.

Then, if he is interested in a specialty, he can enter a residency. If he is interested in general practice, he can obtain employment in a community hospital as a house officer or enter a program designed to train family physicians.

This proposal of a change in our present plan of medical education is offered for your comment and questioning. It saves three years in the education of a physician. It should increase the number of teaching hospitals which are valuable assets to any community. It also continues the supervision of the student during the intern year which is a most important period of his medical training. There are a number of details left out of this discussion because of space limitation. For example, the matter of examinations. If the subject as outlined is worthy of discussion, all of these omissions may be taken up at a later time. It is felt that this new method of education would lend itself uniquely to the problems of limited resources and a narrow academic base we now have in providing medical education in New Jersey.

Operation Lifeline

Cadaver kidney transplantation employing prospective tissue typing and matching has achieved gratifying results in New Jersey, but suitable cadaver kidneys are scarce. To provide organs for the large pool of recipients in the state who are in need of transplantation, *Operation Lifeline* has been instituted.

Whenever you call, the message is relayed to a center where tissue typing and matching with prospective recipients is carried out. The donor patient does not have to be transferred to the recipient hospital since a team of physicians and technologists will conduct all necessary procedures at the organ donor institution. Each response means that needed organs may be provided for one or two patients, and if a matched recipient cannot be found in New Jersey, the kidney will be referred to other recipient pools.

Operation Lifeline is open at all times, and doctors may call any hour of the day or night. The telephone number is (201) 763-1773.

The cooperation of all New Jersey doctors is needed to insure that the rare opportunities to procure kidneys will not be wasted. The New Jersey Regional Medical Program's Sub-Committee on Hypertension and Renal Disease supports the objectives of *Operation Lifeline* and encourages physicians to respond whenever possible. This is a project of the Ruth Gottscho Kidney Foundation.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

INTERNAL MEDICINE—Allan M. Sulzer, M.D., 1148 Plainfield Road, Cleveland, Ohio 44121. University of Pittsburgh 1964. Board eligible. Partnership. Available December 1970.

Luis A. Amill, M.D., 10 East 78th Street, New York 10021. Columbia 1921. Part-time only, hospital, institution, or college. Available August 1970.

OBSTETRICS AND GYNECOLOGY—Roland F. Fleck, M.D., 1061 Nash Avenue, Lansdale, Pennsylvania 19446. Jefferson 1961. Board eligible. Partnership, group, industrial. Available.

Osmundo N. Saguil, M.D., 3328-B Avery Drive, Fort McClellan, Alabama 36201. University of Santo Tomas, Philippines 1961. Board eligible. Partnership. Available January 1971.

OTOLARYNGOLOGY—Phil Brunner, M.D., 5 Clipper Road, Palos Verdes Peninsula, California 90274. NYU (Downstate) 1965. Board eligible. Group. Available August 1970.

James S. Butler, M.D., Bassett Army Hospital (Fairbanks, Alaska), APO Seattle, Washington 98731. George Washington 1963. Board certified. Partnership, group, or solo. Available February 1971.

PATHOLOGY—Frank P. Urso, M.D., 100 Beatty Road, Media, Pennsylvania 19063. University of Miami 1962. Board eligible. Partnership, solo, institution. Available August 1970.

Carl L. Minier, M.D., South Road R.D. #1, Mendham, New Jersey 07945. Jefferson 1929. Board eligible. Hospital. Available.

PEDIATRICS— Howard Singer, M.D., 265 Explorer Street, K.I. Sawyer AFB, Michigan 49843. University of Pittsburgh 1965. Board eligible. Group or partnership. Available October 1970.

Parviz Pishva-Zadeh, M.D., c/o Todaro, 5601 14th Avenue, Apt. 4F, Brooklyn, New York 11219. Tehran 1959. Board certified. Solo or partnership. Available.

Elliott S. Tokar, M.D., 130th General Hospital, APO New York 09696. University of Maryland 1965. Board eligible. Group. Available August 1971.

SURGERY—Edward Mussad, M.D., 115-D Fort Lee Road, Leonia 07605. Cairo University, 1957, Board certified. Group, partnership, or solo (commuting distance New York City). Available.

Y. M. S. Bushan, M.D., 1704-55 Triller Avenue, Toronto 156, Canada. Bangalore Medical College 1961. Board certified. Partnership or group. Available.

UROLOGY—R. Soundararajan, M.D., 6439 North Broad Street, Philadelphia 19126. Madras University (India) 1959. Partnership or group. Available August 1970.

Relative Value Studies

A new edition of the *Relative Value Studies* published by the California Medical Association is now available. The *"RVS"* is a listing of procedures performed by physicians. These units also indicate the relationship of values of services to each other. It became effective for use in California on April 1, 1970. It is a guide to understanding the basis for charges, but it is not a fee schedule.

Major changes are: (1) expansion of the coding system from four to five digits; (2) inclusion of approximately 50 per cent more procedures than in the 1964 edition; (3) introduction of the concept of "modifiers;" (4) structuring of each RVS section unit values in such a way as to make them applicable to only that individual section; and (5) reorganization of the musculoskeletal system in the Surgery Section entirely according to body system.

More than 20 medical specialty subcommittees and a number of individual consultants — comprising nearly 100 physicians — and representatives of the insurance industry, component medical societies, and computerized billing services were consulted in an attempt to make this edition as useful as possible.

The book has an edge index to make it easier to turn to particular sections. The subject index is detailed in its listing of procedures. Cost of the new revised *RVS* is $3.50 (including tax). It is available from Sutter Publications, Inc., 693 Sutter Street, San Francisco 94102.

NOTE: By action of the 1970 House of Delegates, MSNJ, the Fourth Edition of the California Relative Value Index (with necessary updating) was adopted.

ANNOUNCEMENTS

Clinical Application of Basic Sciences

The Burlington County Memorial Hospital in Mount Holly announces its second series of presentations on the general topic of "Clinical Application of the Basic Sciences." Attendance is accepted for credit by the AAGP. The lectures are supported by educational grants from Merck, Sharp, and Dohme, and from Geigy Pharmaceuticals.

The September programs will cover self evaluation technics in improved patient care and continuing medical education on September 3; trends and innovations in medical education on September 10; delivery of personal health services on September 17; and the physician's and the patient's attitude toward illness on September 24. A star-studded faculty has been provided.

The meetings are held on Thursdays at 3:30 p.m. in the Common Room of the T. J. Summey Building of the hospital. For registration and further information, please contact the Department of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060, or call (609) 267-0700, extension 303.

Congress On Occupational Health

September 30 and October 1 are the dates and Los Angeles is the place for the next Congress on Occupational Health. Symposium topics include skiing accidents, car driving by amputees, health problems in Watts, radiation hazards in uranium mining, criteria for flying jet planes (as a passenger, not just a pilot), laboratory hazards to personnel, the role of the industrial nurse, behavioral aspects of accidents, and a dozen other topics. There is no registration fee. For more details write to the American Medical Association's Department of Occupational Health, 535 North Dearborn Street, Chicago 60610.

Course in Gastroenterology

The American College of Gastroenterology announces that its annual course will be given at the Statler-Hilton in New York City, on 29, 30, 31 October 1970. The faculty for the course will be drawn from the medical schools in and around New York. The program covers advances in diagnosis and treatment of gastrointestinal diseases plus a comprehensive discussion of diseases of the esophagus, stomach, pancreas, liver and gallbladder, colon and rectum. For further information and enrollment, write to the American College of Gastroenterology, 299 Broadway, New York, New York 10007.

Glucose Metabolism in Children

"Disorders of Glucose Metabolism in Children" will be reviewed on October 30 and 31, 1970 at the University of Florida College of Medicine, Gainesville, Florida. Sponsored by the University and the National Foundation, this colloquium will feature discussions of diabetes mellitus, hypoglycemias of childhood, and energy metabolism, as well as case presentations. For additional information write to: Division of Postgraduate Education, Hillis Miller Health Center, Gainesville, Fla.

Seminar On Private Practice

The Congress of County Medical Societies has announced meetings scheduled for November 6, 7, and 8, 1970, at the Netherland Hilton Hotel in Cincinnati, Ohio. The program will feature Mr. Robert J. Meyers, Chief Actuary for the Social Security Administration, as the speaker for the Friday, November 6th banquet.

The Academy of Medicine of Greater Cincinnati will act as host for the meeting. Dr. Richard Fulton, President-Elect of the Ohio State Medical Association, will be the keynote speaker. You are invited to attend.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1970

September

3 **Burlington County Memorial Hospital**
Mount Holly
Improved Patient Care and Continuing Medical Education

10 **Burlington County Memorial Hospital**
Mount Holly
Medical Education

17 **Columbia Physicians and Surgeons Medical Center**
New York City
Acute Respiratory Insufficiency Management

17 **Burlington County Memorial Hospital**
Mount Holly
Future Patterns of Medical Care

20 **New Jersey Dermatologic Society and Academy of Medicine of New Jersey**
Nassau Inn, Princeton

24 **Burlington County Memorial Hospital**
Mount Holly
Physician's and Patient's Attitude Toward Illness

30 **Beth Israel Medical Center**
Newark
Bedside Treatment of Shock

October

3-4 **New Jersey Heart Association**
Holiday Inn, Atlantic City
Coronary Care in the 1970s

5-9 **Beth Israel Medical Center**
Newark
Vectorelectrocardiography

7 **St. Michael's Medical Center**
Newark
Hematology

14 and **Neurological Institute of Health**
21 New York City
Neurology

21 **St. Michael's Medical Center**
Newark
Pleural Effusion

28 **St. Michael's Medical Center**
Newark
Asthma and Allergic Disease of the Lungs

28 **St. Michael's Medical Center**
Newark
Advances in Esophageal Disease

November

4, 11, **St. Michael's Medical Center**
18 Newark
Advances in Esophageal Disease

4 **St. Vincent's Hospital and Medical Center**
New York City
Isotope Scanning of Lung, Liver, and Spleen

11 **St. Michael's Medical Center**
Newark
Infectious Disease

12 **St. Michael's Medical Center**
Newark
Renal Disease

18 **St. Michael's Medical Center**
Newark
Fever of Unknown Origin

December

3 and **St. Barnabas Medical Center**
4 Livingston
Culdoscopy Workshop

9 **St. Michael's Medical Center**
Newark
Pulmonary Disease

LETTER TO THE JOURNAL

Reply From NJCMD

May 8, 1970

Dear Dr. Davidson:

Thank you for giving Dr. Rawson, our Dean of Medicine, and myself the opportunity to respond to Dr. Brodkin's letter. We both regret that we were not familiar with his 1964 report, but are pleased to report to him and to our professional colleagues in New Jersey, that we are implementing all of his suggestions which fall under our control. We are already working on the development of a three year curriculum and have stimulated changes in the State's medical practice acts to permit this shortened schedule. We are inaugurating a program this Fall which will permit 12 young New Jersey men or women currently in foreign medical schools to transfer to us after completing their studies of basic biomedical sciences providing they pass Part I of the National Board Examinations. They will complete their clinical education under our faculty and, accordingly, will graduate with an American degree. This should alleviate any licensing problem at least for these individuals. If this experiment proves successful we will expand the program. Speaking of numbers, we have pledged to the Governor that when our new facilities are built, we will accept 150 entering medical students and by accepting transfer students into the clinical curriculum to graduate some 200 per year. Our dental class will be likewise increased to 120 over the 80 originally planned.

We concur with Dr. Brodkin's suggestion of using community hospitals as a method of expanding clinical education and already have affiliations with hospitals in and around Newark giving us a total of 2200 beds for this specific purpose.

We know that Governor Cahill has made certain proposals regarding medical and dental education in New Jersey, and our faculty and student bodies join us in supporting his recommendations, as we currently understand them. We look forward, as do all physicians in New Jersey to a system of medical education in our State of which we all can be justly proud.

(signed) Robert R. Cadmus, M.D.
President, NJCMD

OBITUARIES

Dr. Ivan Barchenko

At the age of 73, Ivan Barchenko, M.D., died on June 19, 1970. Dr. Barchenko was born in the Ukraine in 1897. He was graduated at the age of 28 from the medical school of the University of Kiev. Dr. Barchenko came to the United States in the early 1950s and, after a residency at the Swedish Hospital in Brooklyn, settled in Passaic. He was a family doctor, affiliated with the Passaic General Hospital.

Dr. Edwin T. Bruce

Word has just been received of the death last December of Edwin T. Bruce, M.D. of Brant Beach, New Jersey. Born in 1911, he was a 1937 graduate of the Medical School at Temple University. He was a captain in the Medical Corps of the Army of the United States during World War II. Dr. Bruce was an active member of our Ocean County component.

Dr. Arey A. Butterfield

Arey A. Butterfield, M.D. came to our state in 1914, at the conclusion of his internship. He had been born in Maine and, except for his medical school years, he had lived there until he decided to settle in Pasaic County. Dr. Butterfield won his M.D. degree at Hahnemann in 1914 at the age of 24. He was a gynecologist, well-known in Passaic and affiliated with the General Hospital there. Dr. Butterfield died on May 16, 1970 at the age of 85.

Dr. Ellis J. Chapman

Not many members of the Jefferson Medical College, class of 1906, are still around. But Ellis J. Chapman was one of them . . . and now, since his death on May 16, 1970, that link is dissolved. A diplomated surgeon, he was, for years, medical director of Jersey City's Greenville Hospital. He had a tour of duty as president of our Hudson County Medical Society, and had, indeed, served in almost all the offices of that component. Dr. Chapman was 86 years old at the time of his death.

Dr. Edgar J. Evans

On June 17, 1970, Edgar Evans, a well-known Morris County practitioner, died at the age of 62. He received his M.D. at the Medical School of Temple University in Philadelphia in 1934. He was active in committee work for our Morris County component society. Dr. Evans was a general practitioner on the staff of St. Clare's Hospital in Denville, in which community he had practiced medicine more than thirty years.

Dr. John H. D. Finke

One of our state's senior practitioners, John H. D. Finke, M.D., died on April 30, 1970, at the grand age of 86. He was a 1910 alumnus of the old Long Island College of Medicine, and was, for a half century, a family doctor of the old school. He was an early member of the Hackensack Hospital staff, and was for decades active in the affairs of our Bergen County Medical Society.

Dr. Howard J. Isenberg

His many friends, colleagues, and patients were shocked, on May 22, 1970, to learn of the death on that day of Howard J. Isenberg, M.D., at the untimely age of 47. Dr. Isenberg, a Passaic internist, was a 1948 graduate of the medical school of Harvard University. He was affiliated with both the Beth Israel Hospital and the General Hospital in Passaic.

Dr. Frank C. Keil

At the untimely age of 48, Dr. Frank C. Keil, a Plainfield pediatrician died on June 6, 1970. Dr. Keil was graduated from New York Medical College in 1946, and after completing a residency in pediatrics, he entered private practice in Plainfield. He was on the staff of the Muhlenberg Hospital.

Dr. Carl H. Menge

One of Ocean County's best-known practitioners, Carl H. Menge, M.D., died at his home in Toms River on April 14, 1970. Dr. Menge was an otolaryngologist affiliated with Newark Eye and Ear Infirmary and the Paul Kimball Hospital in Lakewood. Born in 1900, he received his medical degree at the University of Tennessee in 1927.

Dr. Foster Orton

Born in 1911, Foster Orton, M.D., a Rahway surgeon, died on May 16, 1970. He was an FACS and was an attending surgeon at the Rahway Memorial Hospital. Dr. Orton was active in committee work for the Union County Medical Society and in civic affairs in Rahway where he had his office. He received his M.D. degree in 1936 at the University of Pennsylvania.

Dr. John W. Prather

Word has just been received of the death on May 19, 1970 of a well-known New Jersey obstetrician and gynecologist, John W. Prather, M.D. Born in 1894, he was 76 at the time of his death. Dr. Prather was graduated from the University of Pennsylvania in 1921. He was board-certified in his chosen specialty, an FACS, and for years had served both the

Holy Name Hospital in Teaneck and the Englewood Hospital. He had lived in Dumont most of his active professional life, but was living in retirement in Reinbeck, New York, at the time of his death.

Dr. Max Preminger

One of our State's relatively few physicians with dedicated interest in geriatrics, Max Preminger, M.D., died on May 9, 1970, at the age of 60. He received his M.D. at Friedrich Wilhelms University in Berlin in 1937, and came to this country shortly thereafter. He settled in southern New Jersey and became an associate attending internist at the Newcomb Hospital in Vineland. He was active in the affairs of the New Jersey division of the American Geriatric Society.

Dr. William T. Rummage

One of the pioneer ophthalmic surgeons of New Jersey, William T. Rummage, M.D., died on April 25, 1970, at the great age of 84. He was a 1912 graduate of the old Baltimore College of Physicians and Surgeons. Dr. Rummage lived in South Orange during the last decade of his life, but prior to that he had been identified with the Eye and Ear Infirmary and the St. James Hospital in Newark.

Dr. Benjamin Saslow

Benjamin Saslow, M.D., was one of the earliest of our state's doctors to be interested in metabolism in general and diabetes in particular. He was board-certified in internal medicine and a Fellow of the American College of Physcians. Born in 1900, he was a 1924 Bellevue graduate. He was affiliated with both the Presbyterian Hospital (now United Hospitals of Newark) and the Newark City Hospital (now Martland Division of the Medical College Hospital). Dr. Saslow died on April 25, 1970. His widow, also a physician, is a member of The Medical Society of New Jersey.

Dr. Carl A. Surran

While in Florida, Carl A. Surran, M.D., formerly of Margate, died of a cardiac attack on June 5, 1970. Dr. Surran was born in 1890, received his M.D. at Georgetown in 1915, did general practice and was police surgeon in Atlantic City. He was affiliated with the U.S. Public Health Service. In 1965, he was the laureate of a Golden Merit Award of The Medical Society of New Jersey. Dr. Surran served during World War I as a Major in the Medical Corps.

Dr. Henry T. Weiner

The attending proctologist at the Perth Amboy General Hospital, Henry T. Weiner, M.D., died on June 13, 1970, at the age of 63. Born in Cleveland, he received his M.D. degree at the University of Cincinnati in 1937. After finishing internship in Ohio, he came to Perth Amboy in 1939 and he moved to New Brunswick in 1966. Dr. Weiner taught proctology at the New York Medical College and he was a founding member of the New Jersey Proctology Society. Dr. Weiner was also active in the affairs of our Middlesex County Medical Society.

Dr. Hugh M. White

One of our State's senior practitioners, Hugh M. White, M.D., died on April 13, 1970 at the grand age of 90. Dr. White had earned his M.D. at Bellevue in 1910. He was a general practitioner on the staff of Christ Hospital in Jersey City, and was a member of our Hudson County Medical Society. Dr. White had retired from active practice some 25 years ago.

Dr. Walter L. Widmark

At the age of 53, Walter L. Widmark, M.D. of Montclair, died on May 24, 1970. He was a 1941 alumnus of the Duke University School of Medicine, who had served a residency in obstetrics and gynecology at the University Hospital there. From 1942 to 1946, he was on active duty in the Navy, reaching the rank of Lieutenant Commander. He was in the thick of the action on the U.S.S. Jeffers, winning five battle stars. On discharge from the Navy he returned to his native city, Montclair, and was on the staffs of both the Community Hospital and the Mountainside Hospital.

BOOK REVIEWS

Synopsis of Clinical Cancer. Condict Moore, M.D. St. Louis, 1970. Mosby, Pp. 267. ($11.75)

This new synopsis lives up to its name. It gives a methodical presentation of the subject without going into endless detail, and thus forms a basis for a good clinical review. The book has thirty-four chapters, each dealing with cancer in a specific organ or part of the body. Chapter subdivisions contain the usual headings of incidence and distribution, etiology with predisposing factors, pathology including precancerous lesions, diagnosis with laboratory work-up, current treatment and prognosis. In addition there are subtitles on the natural history of each cancer, differential diagnosis, preventive measures, errors made during diagnosis, and possible future developments relating to cancer in each organ or portion of the body involved in the process.

The text reviews carcinogenesis, cancer in children, chemotherapy, and end result reporting in cancer. Central nervous system tumors were not described in this book.

There is a clinical guide which will serve as an up-to-date review for the family physician. It is useful to the specialist who knows his own field, but is not familiar with cancer therapy and technics in adjacent fields. Dr. Moore has written a fine synopsis which will up-date the student or practicing physician on the subject of cancer.

GEORGE F. COWLING, M.D.

Handbook of Psychiatry. Philip Solomon, M.D. and Vernon D. Patch, M.D. Los Angeles, 1969, Lange Medical Publications. Pp. 623. (Softback, $7)

"This *Handbook*," says Dr. Solomon in his preface, "may be the only multiple authorship medical book with such a high proportion of juniors among its contributors." This is a new idea in anthologies, and probably a good one. In medicine as, indeed, in most organized professional groups, seniority wins status. But having not done so well in running the world, maybe it's about time we seniors took a back seat.

The book strikes a remarkably happy balance between the talking-down superficiality of the once-over-lightly compendia, and the weightiness of the advanced tomes. An "emergency psychiatric routine" in the inside back cover, for instance, is a useful, unique, and refreshing idea in psychiatric texts. The book starts with a chapter on patient-doctor relationships—a logical beginning, yet an unusual one. The scope of coverage is extraordinary. From genetics to psychiatric practices in a college; from psychologic testing to psychopharmacology; from psychiatric history to utilization of electric shock; from psychiatric nursing to forensic psychiatry. If a medical student, family doctor, or nonpsychiatric specialist were limited to a single volume in psychiatry, he could go much further and do much worse than to put this little book on his shelf or in the deep side drawer of his desk.

HENRY A. DAVIDSON, M.D.

Training Therapist For Tongue Thrust Correction. Ann Beard Ehrlich, B.A., C.D.A. Springfield, Illinois, 1970, Charles C. Thomas. Pp. 136. Illustrated. ($7.50)

During a typical swallow, the mandible is braced against the maxilla by the temporal, masseter, and internal pterygoid muscles; the tip of the tongue is placed slightly behind the superior anterior maxillary teeth and the tongue exerts a powerful distal thrust to force the bolus into the pharynx.

In the usual tongue-thrust swallow, the tip of the tongue is placed against the anterior maxillary teeth. The teeth do not contact and the circumlabial and buccinator muscles assist the distal thrust of the tongue.

Tongue-thrust, because of the excessive pressure against the anterior teeth, may cause an impaired dental alignment, somewhat resembling a "Bugs Bunny" picture.

The author intends the book as a training manual for tongue-thrust therapists, but there is sufficient useful information for all doctors and perhaps laymen. She lists several diagnostic signs and excellent technics for remedying many conditions.

The text was poorly edited. Tongue and muscle are nouns; they should be hyphenated when used as adjectives. On page 49, "access" was used instead of "assess."

The text is redundant; it could be shortened. On page 121, Bibliography is the main heading and Reference the sub-heading. "Bite your teeth together" and "mouth closed with lips together" are other redundancies. The author constantly repeats statements and quotes that make for tiresome reading.

WOODROW S. MONICA, D.M.D.

Medicine and Stamps. R. A. Kyle, M.D. and M. A. Shampo, Ph.D., Editors. Chicago, 1970, American Medical Association. Pp. 216. Illustrated. ($4)

Medicine and Stamps is a compilation of biographies of physicians and medical scientists that appeared as space fillers, under the title of "Medical Pathfinders on Stamps" in the *JAMA*, with some revisions and additions to the series supplied by the late John A. Mirt. In this well printed volume, the biographies are arranged alphabetically. Each biography is illustrated with a stamp honoring the individual.

The authors have done a nice job and this volume should be of interest to collectors interested in all phases of "medical stamps." The table of contents lists each individual honored with the stamp number (Scott) and the page on which it appears. The index lists each individual honored according to the field of medicine in which he was particularly identified.

There are several errors. Leeuwenhoek is credited with being the inventor of the microscope. Johannes Jansen and his son Zacharia, of Middleburg, Holland, invented the microscope 42 years before Leeuwenhoek's birth. He is also described as a janitor and draper. Leeuwenhoek did have a dry goods store, served as Chamberlain to the Sheriffs, acted as surveyor, and for 40 years was wine-gauger for the city of Delft. He ground lenses and made his microscopes and did his research work in his spare time. He was the first to see protozoa and bacteria. He is the father of microscopy. Donders is described as the inventor of the ophthalmoscope. Donders invented the retinoscope but Helmholtz is credited with the invention of the ophthalmoscope.

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Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

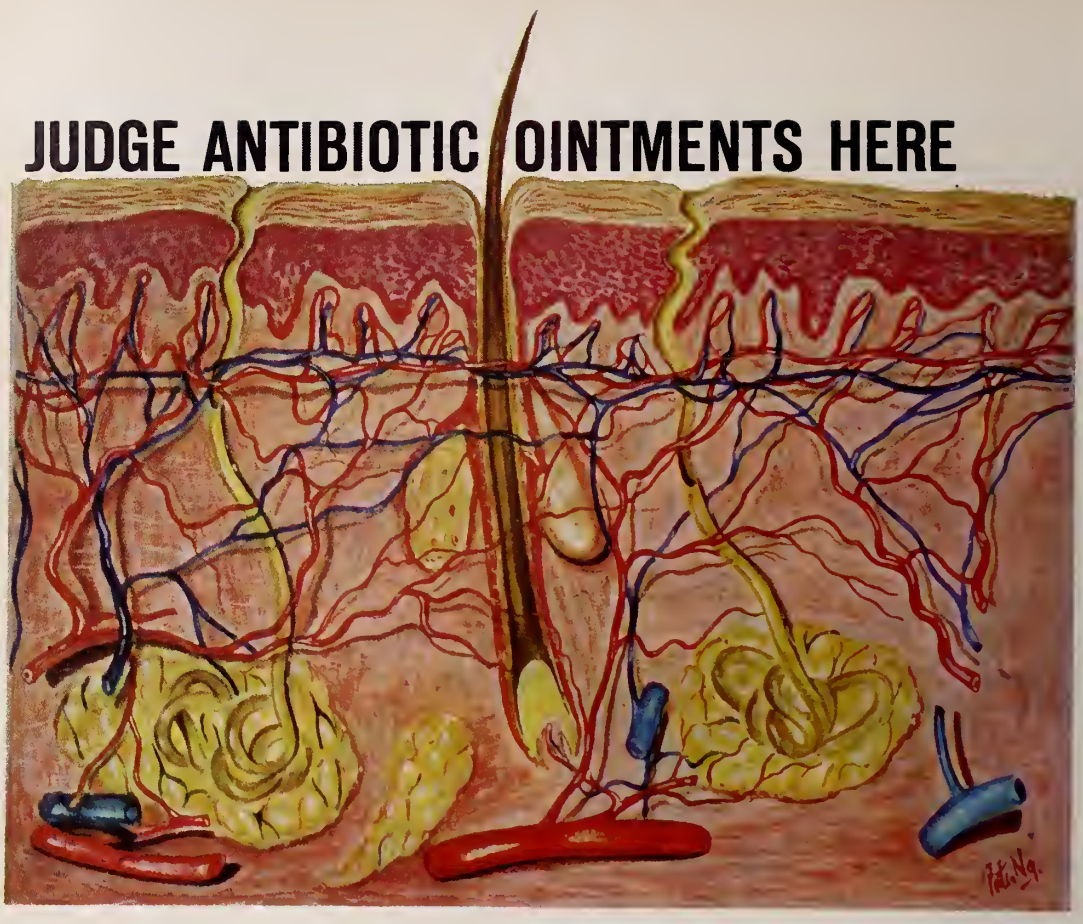
Dosage Forms: Oral tablets . . . 250 mg.
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*References available on request.

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NOTE: *The high therapeutic index of Trocinate permits an alternation in dosage sufficient to relax smooth muscle spasm promptly. 400 mg. dosage usually proves a therapeutic blood level. In relaxing dosage after relief, lengthening the time between doses rather than lessening the recommended dose is preferable. The prompt direct action allows a continuance of the first regimen of return of symptoms. A guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a recurrence.*

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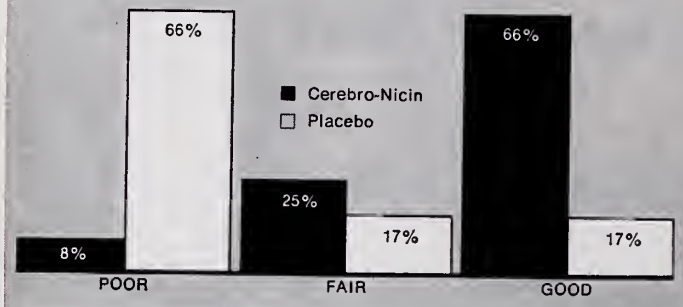
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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The treatment of

impotence

NEW CLINICAL STUDY

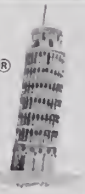
In the American male is complex. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

The Treatment of Impotence with Methyltestostarone Thyroid (100 patients—Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Officiel Journal of the American Fertility Society



Android®

(thyroid-androgen) tablets



Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Ketosteroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications – Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966 2. Dubin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:87, 1964 3. Trieff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:836, 1959. 5. Farris, E. J., and Colton, S. W. Effects of l-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed 25). Lippincott, Philadelphia, 1955. p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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L-lysine	100 mg.
Glutamic Acid Hydrochloride	60 mg.
Ferrous Nicotinate	17.85 mg.
Equivalent to Nicotinic Acid	12.5 mg.
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Vitamin A	2,500 U. S. P. Units
Vitamin D	250 U. S. P. Units
Thiamine Mononitrate	2.5 mg.
Riboflavin	2.5 mg.
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Vitamin B-12	1.5 mcg.
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Inositol	10 mg.
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Manganese (from Manganese Sulfate)	0.5 mg.
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Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

ACTION AND USES—*DOSAGE:* 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. *PRECAUTIONS:* Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. *CONTRAINDICATIONS:* Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. *AVAILABLE:* Bottles of 30, 100, and 500 tablets. Rx only. Also available: Testand-B injection . . . vials of 10 cc.

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See Clinical Considerations section on last page...

Injectable Garamycin®
brand of gentamicin sulfate injection

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ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	Resistant/ Moderately Severe	Serious/Life-Threatening
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.20 5-619

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Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL, One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U S PATENT NO 3,001 910

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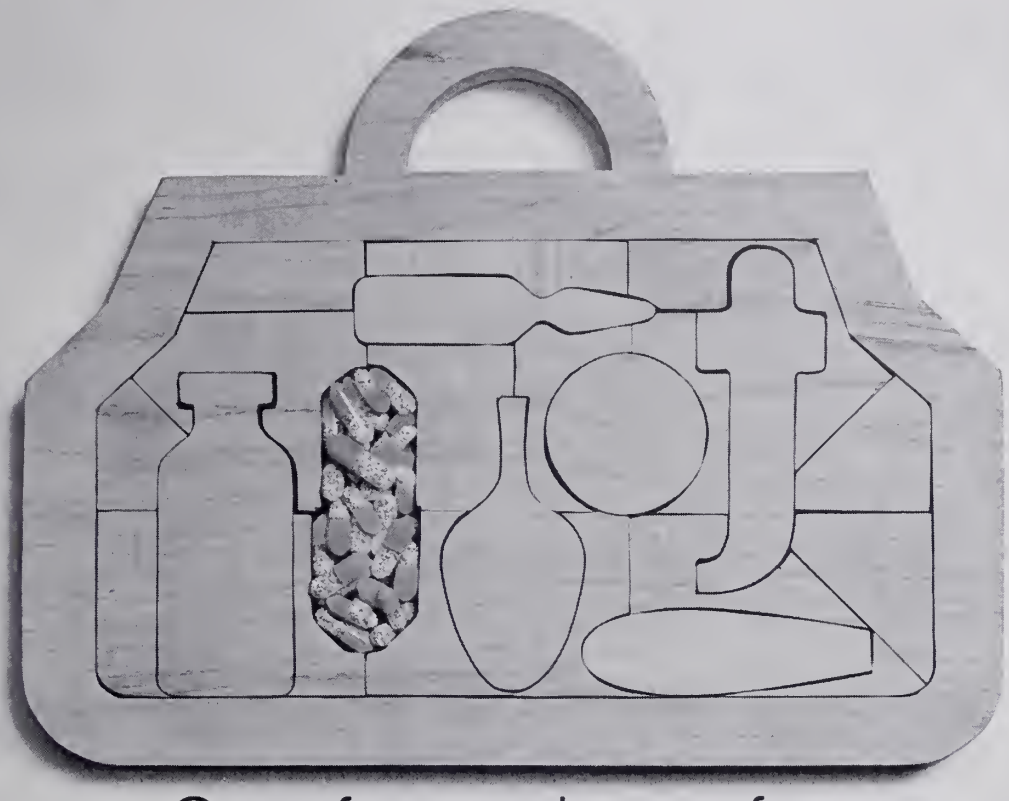
Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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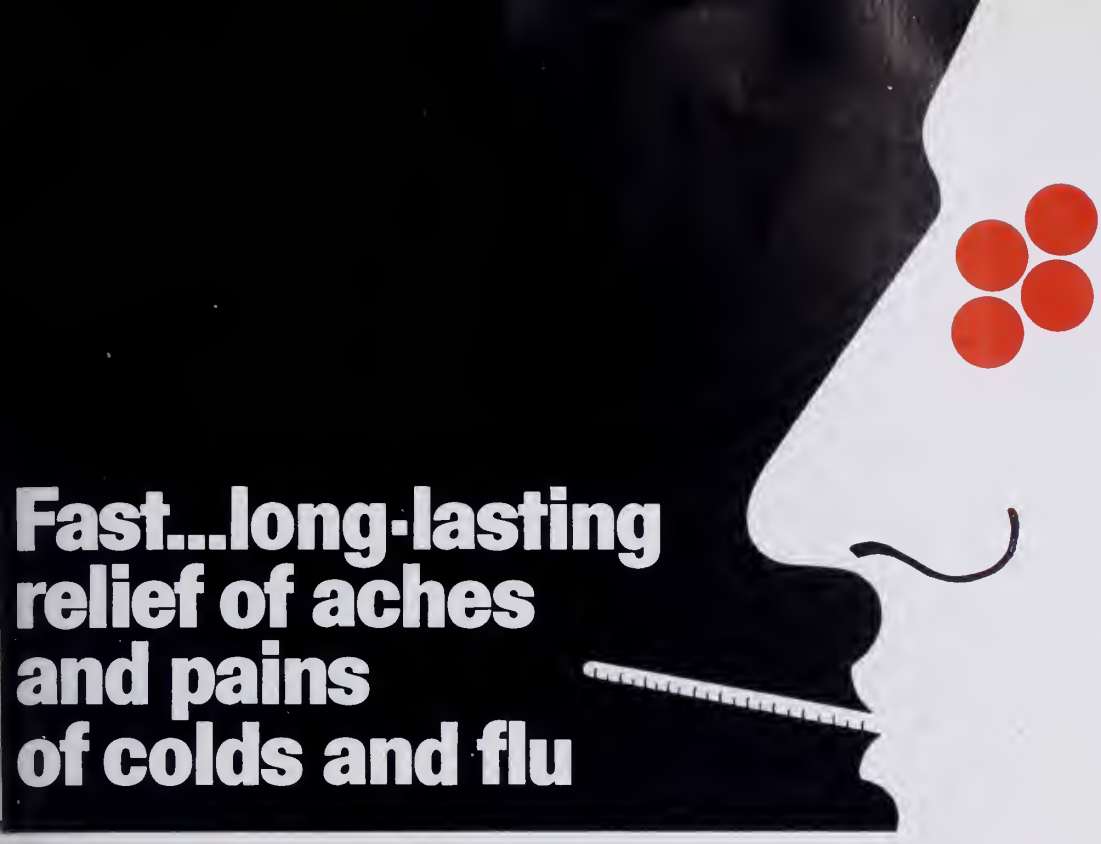
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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SEPTEMBER 1970
VOL. 67, NO. 9

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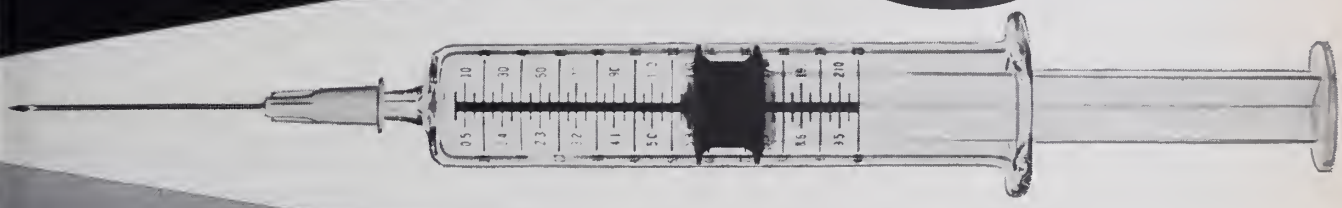
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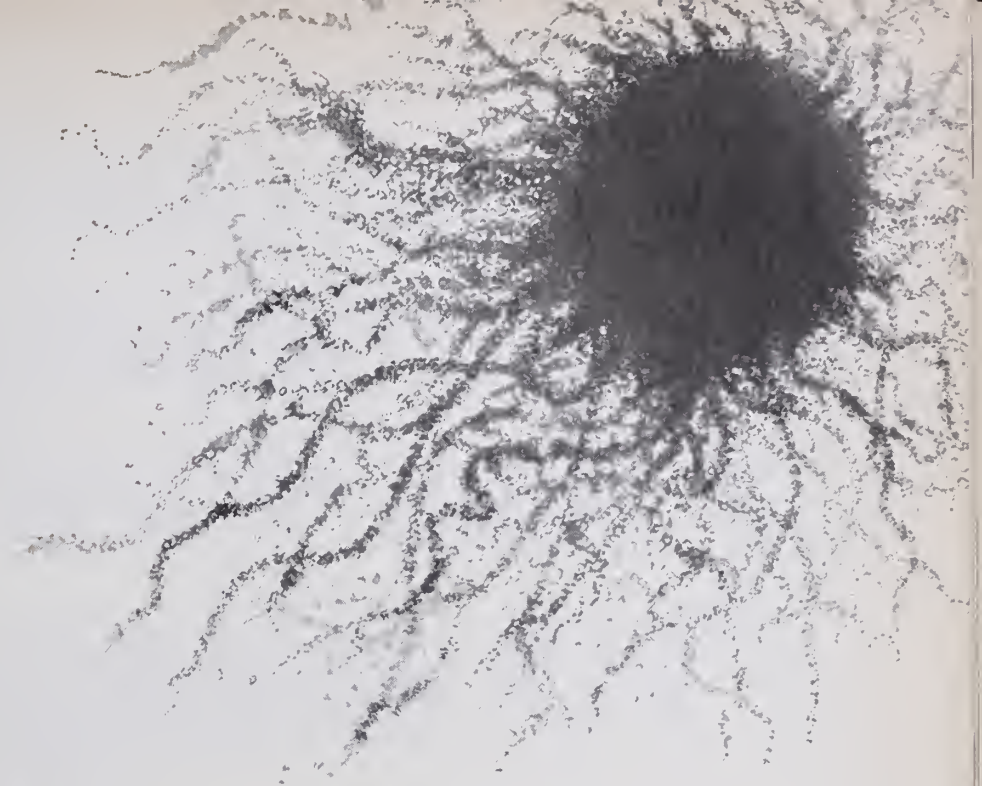
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes, a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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If your usual charges fall within the range of fees charged by at least 90 percent of your colleagues in your specialty and practicing in a similar locality, you can become a Prevailing Fee Participating Doctor and Blue Shield will pay those charges in full, directly to you. These fees are not set by Blue Shield—they are set by 90 percent of the physicians themselves, according to their charges on file with the Plan.

It is understood that usual and customary fees are influenced by the general economy and will not remain static. The Prevailing Fee Program will not remain static, but will be responsive to changes in the economy in future years.

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programs. Even though you may be a Participating Physician for basic coverage, it is necessary to sign a separate agreement for Prevailing Fee participation.

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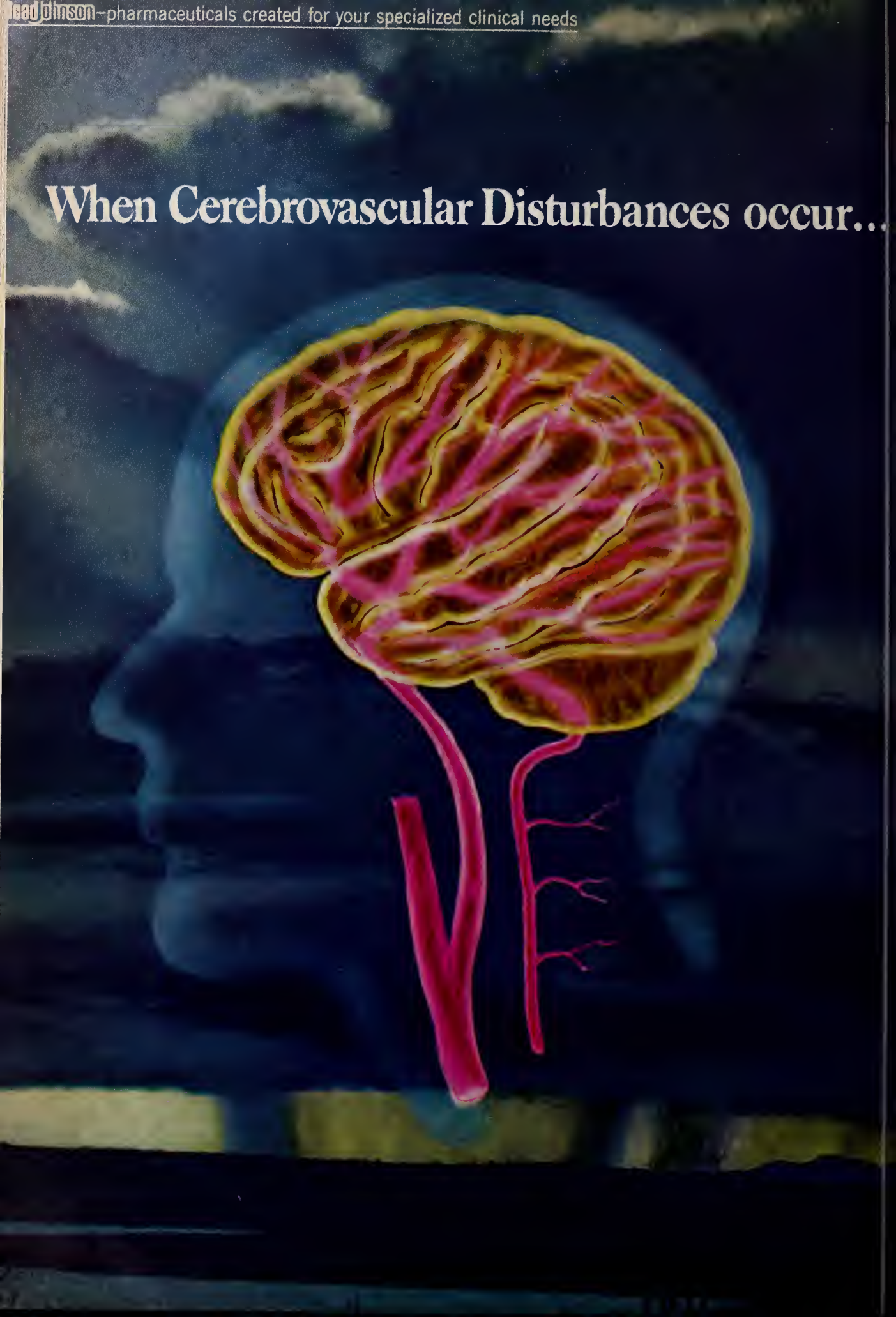
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Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in i dividuals with a history of hypersensitivity or toxic reactions gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whoi serious infection develops, serum concentrations of the drug ma rise, with consequently increased risk of ototoxicity. In these pa tients or in those in whom recommended dosage or duration c therapy must be exceeded as a life-saving measure, routine studie of kidney function should be performed when possible. These ma be supplemented by evaluation of the vestibular and auditory func tion and measurement of serum concentration of the drug whe feasible. Serum concentrations of gentamicin should be maintaine below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 1 days or be repeated unless required for serious infection not re sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectabl may occasionally result in overgrowth of nonsensitive organisms. I superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity o nephrotoxicity have not been established. Studies in pregnant ani mals have not revealed teratogenic or ototoxic effects in the fetu GARAMYCIN Injectable should not be used in pregnant patients o in women of childbearing age unless its use is deemed advisabl by the physician.

Adverse Reactions: The overall incidence of ototoxicity considere related to treatment with GARAMYCIN Injectable was 2.8 per cen (16 of 565 patients). Contributory factors (two or more factors wer relevant to most patients) were as follows: 10 had azotemia, 1 received a total of 1 gram or more of the drug, 7 had recently re ceived other potentially ototoxic antibiotics (streptomycin or kana mycin), and 5 were over 60 years of age. Six also had decrease high-tone hearing acuity, which returned to or toward normal i the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showe increases in BUN that were probably related to treatment wit GARAMYCIN Injectable. Of 20 increases probably or possibly relate to treatment, 7 were reversible, 9 occurred in terminal patients, an 4 had no follow-up.

Other adverse reactions associated with treatment were one instanc each of urticaria, decreased hematocrit, and reversible depressio of granulocytes with normal bone marrow. Other rarely reporte and possibly treatment-related adverse reactions were anemia, in creased reticulocyte count, rash, purpura, drug fever, hypotension convulsions, twitching, salivation, nausea, vomiting, increased trans aminase activity (SGOT or SGPT), increased serum bilirubin, de creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dos vials, for intramuscular administration.

For more complete prescribing details, consult package insert o Physicians' Desk Reference. Schering literature is also availabl from your Schering Representative or Medical Services Department Schering Corporation, Union, New Jersey 07083.

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Menrium® treats the menopausal symptoms that bother him most.



Roche
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ision of Hoffmann-La Roche Inc.
tley, New Jersey 07110

His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through *her* menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

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SUSTAINED-RELEASE VITAMIN C



CEVI-BID

500 mg. capsules maintain optimal levels around-the-clock on b.i.d. dosage

When Vitamin C is taken in ordinary tablet form, the rise in blood levels is rapid, but Vitamin C is as rapidly excreted and blood levels drop accordingly.

In CEVI-BID, medication is released at a smooth, continuous, predictable rate dependent only upon the presence of fluid in the G.I. tract and independent of pH or other variables.

CEVI-BID maintains optimal blood levels of Vitamin C, and avoids "peak and valley" effects of ordinary Vitamin C tablets.

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What the doctors in this country need is a simple, accurate lab system for under $600.



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Physicians can't operate their offices like doctors did in the old days.

That's when the patient load was lower and so was the overhead, in case you wanted to have lab tests performed right on the premises. There were a lot more qualified technicians for hire, too. Or if you didn't want the bother and payroll of a bigger staff, you sent specimens out to a local lab or a nearby hospital. Then you waited for results to return and added the charge to the bill.

Problem is, that way isn't economically feasible any longer. More sophisticated lab tests have been developed to aid your diagnosis. Fewer skilled personnel are available. The complex equipment required is more expensive. And the cost of space is premium.

Somebody had to solve this kingsized problem. We did.

We perfected the compact UNITEST SYSTEM. You start with the heart and brains, the Unimeter. It sells for below $600. Far below, in fact. Then, you add-on components you don't already own. When you're done, any qualified person in your office can run 14 tests for the most commonly-needed determinations. That includes Blood Glucose, Hemoglobin, B.U.N., Uric Acid and Cholesterol.

And you get accurate test results faster, often before the patient leaves.

Yes, the compact UNITEST SYSTEM is a lot smaller than you'd expect for equipment that does so much. And there are so many functions it does so well, you really owe it to yourself to get more information. Some is on the following page. The card below will bring you all of it. Just complete, detach and mail.

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I am interested in receiving more information about use of the UNITEST SYSTEM in my office.

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The UNITEST SYSTEM provides these important features:



The Unimeter—The Unimeter 250 is a precisely-calibrated, solid state colorimeter. Rugged in design and simple to operate, it has only three controls: on-off switch, calibration control dial and temperature control button.



The Select-a-Fuge 24 — The most advanced centrifuge in its category ever developed . . . a single unit capable of performing *three* centrifugated preparations where at least two units were previously required . . . and in the shortest possible time for each specimen involved. The Select-a-Fuge 24 can prepare urine specimens at the low speed of 4000 rpm . . . or perform uniformly consistent serum, plasma and hematocrit results at 10,000 rpm. Other preparations requiring graduating intermediate speeds may also be conducted. Select-a-Fuge 24 does all this without changing equipment, without adding or removing parts.



Built-in Incubator — The Unimeter has a convenient built-in incubator which holds twelve tubes at a constant temperature of 37°C. There is an instant push-button temperature check.



Interchangeable Meter Faces—The slip-in meter face cards with color-coded test scales allow the operator to adapt this unit to a variety of tests and to incorporate any new tests which may be added in the future.



Push Button Pipetting—Automatic Pipette controls critical measurements precisely with remarkable ease and speed. Assures dependable results between operators, regardless of their individual skills.



Unitube—The optically correct, glass Unitube contains reagent materials. It also contains the reaction and is used as a cuvette, when the reaction is complete. After the result is recorded the Unitube is discarded. Unitube caps are color-coded for each test.



Unitest Kits — Each kit contains everything necessary to perform the tests. Everything is pre-measured, color-coded, sealed against contamination and disposable. Simple, step-by-step illustrated instructions are enclosed in every kit. Kits are available in a variety of sizes.

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Remember how great milk of magnesia tasted?

Almost as good as castor oil.
But now you can spare the taste buds and spoil the patient with a modern Dulcolax tablet or suppository.

And Dulcolax works so predictably that the time of bowel movement can often be predicted. Tablets taken at night usually produce a bowel movement the following morning. Suppositories generally work in 15 minutes to an hour.

For preoperative preparation, a combination of tablets at night and a suppository the next morning usually cleans the bowel thoroughly.

Dulcolax suppositories may be particularly helpful when straining should be avoided, as in postoperative care. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable
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"What she really needs, Doctor, is a shot of penicillin

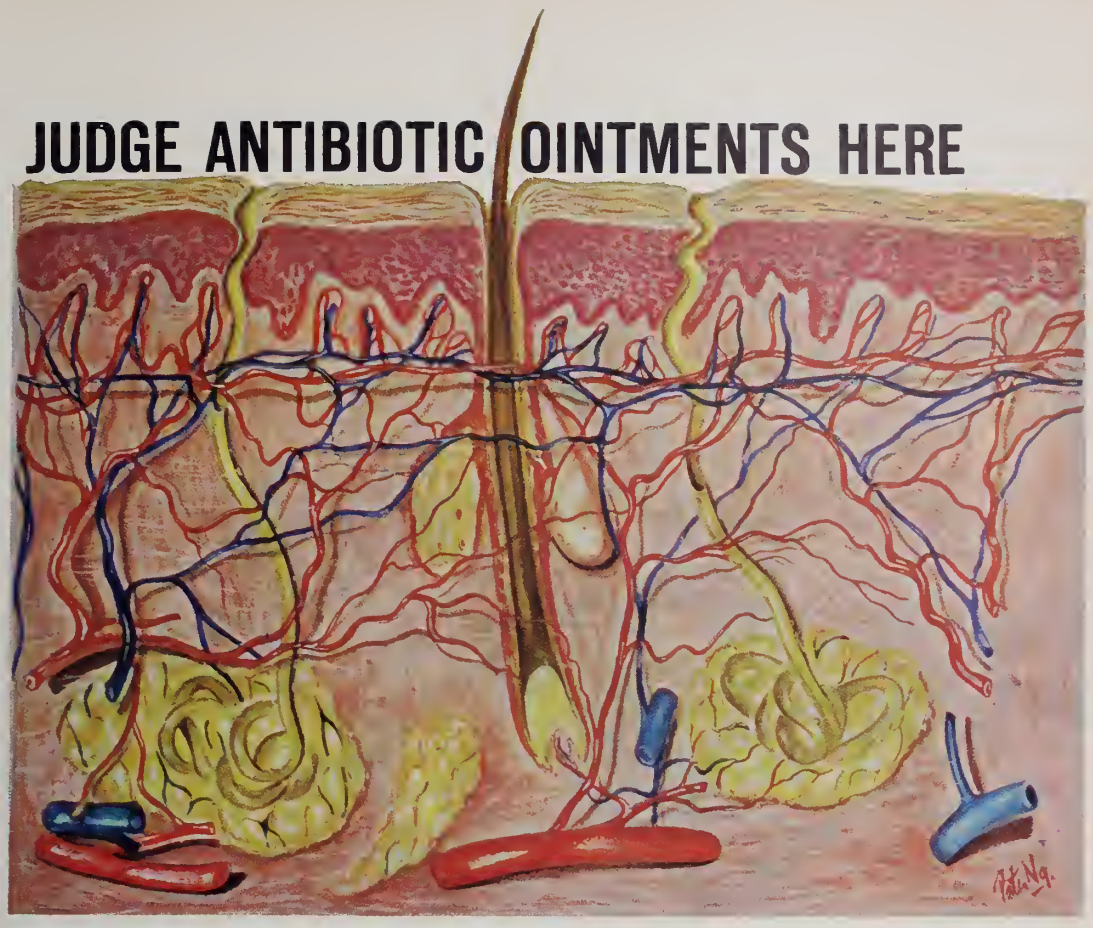
Maybe. Maybe not. In any case she needs something to control her sneezing, watery eyes and runny nose. And for most children over six, Novahistine® LP can be depended on to provide fast relief from summer colds and allergy. These continuous-release tablets have a vasoconstrictor-antihistamine formulation that begins working in minutes, then continues to provide relief for hours. A single Novahistine LP tablet, morning and evening, can keep most young patients free of symptoms all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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Clinical Extension of a pure Smooth Muscle Relaxant

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400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS . . . *the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relax smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. To relieve dosage after relief, lengthening the time between doses rather than lowering the recommended dose is preferable. The prompt direct action allows a continuous use of the first suggestion of return of symptoms. A guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct pain and leave a few tablets for a recurrence.*

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Biochemical Procedures opens a new era in laboratory medicine... combining the **accuracy** and **wealth of experience** only a reference laboratory can provide, with the **economy** to you and your patients available only through automated testing. ☐ Add to this the **broad spectrum** of tests available, plus the **versatility** of test selection, and the speed and convenience of air mail, and you have the Biochemical Procedures concept. ☐ You select the tests which best suit the needs of your practice and your patients... **Standard Profiles**—test groups to meet specific clinical conditions or general medical screening; **"Select Your Own Profile"**—offering you the versatility of combining three or more of the 24 most frequently utilized tests at significant savings over individual test fees; **Individual Tests**—with more than 800 test types, ranging from routine to the unusual and esoteric. ☐ All testing is supervised by a Board-Certified member of the American Board of Pathology. Equipment is the most modern and sophisticated in the industry. Reporting of results is immediate, by phone when necessary. ☐ Call or write the Division listed below for additional information and supplies.

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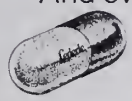
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In 1936 A. E. Smith, professional at Woolcombe, England, recorded the lowest golf score for an 18 hole course. He shot a 55 and was 15 under par. The course at Woolcombe, which measured 4,248 yards, was covered in 4, 2, 3, 4, 2, 4, 3, 4, 3 out and 2, 3, 3, 3, 3, 2, 5, 4, 1 in.

is worth doing well.

Take ACHROMYCIN V, for example. Lederle routinely runs over 1,000 quality control checks on every batch produced. Many, many more than officially required. This extra attention means your patients get what the doctor ordered when you prescribe ACHROMYCIN V: uniform *in vitro* dissolution rate, predictable *in vivo* serum and urinary levels. In short, known biologic availability of tetracycline. And every step in the production of ACHROMYCIN V is in-house controlled right in Pearl River.



ACHROMYCIN®-V
Tetracycline HCl

Performance proved in practice

Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.
Contraindication: History of hypersensitivity to tetracycline.
Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.
Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.
Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.
Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

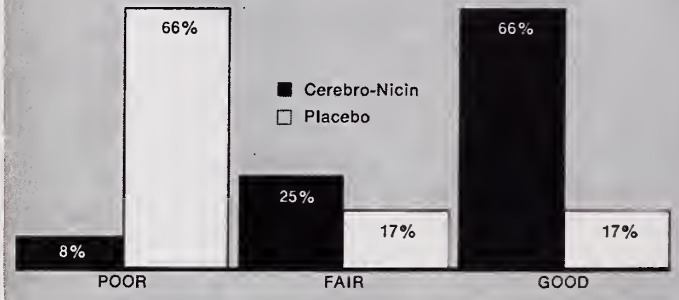
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For the treatment of the aging patient

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8 oz. bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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Write for Product Catalog

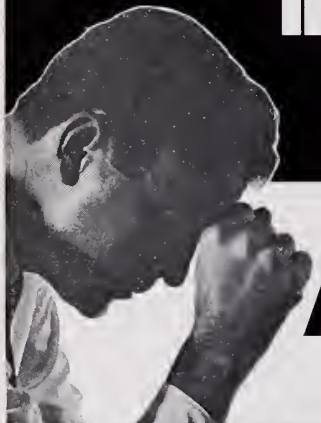
The treatment of

impotence

NEW CLINICAL STUDY

in the American male is complex. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study) T. Jakobovits Fertility and Sterility, January 1970 Official Journal of the American Fertility Society



Android®

(thyroid-androgen) tablets



Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Ketosteroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow tablet contains:
Methyl Testosterone .. 2.5 mg.
Thyroid Ext. (1/6 gr.) .. 10 mg.
Glutamic Acid ..... 50 mg.
Thiamine HCL ..... 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (1/2 gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL ..... 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone ..12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid ..... 50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone .. 2.5 mg.
Thyroid Ext. (1/4 gr.) .. 15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL ..... 5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate ..10 mg.
Vitamin B-12 ..... 2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications – Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease. Hypertension unless the metabolic rate is low.

References: 1. Moniesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dubin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tiferi, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and isothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Dial, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1958, pp. 79-95.

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Write for literature and samples: BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057
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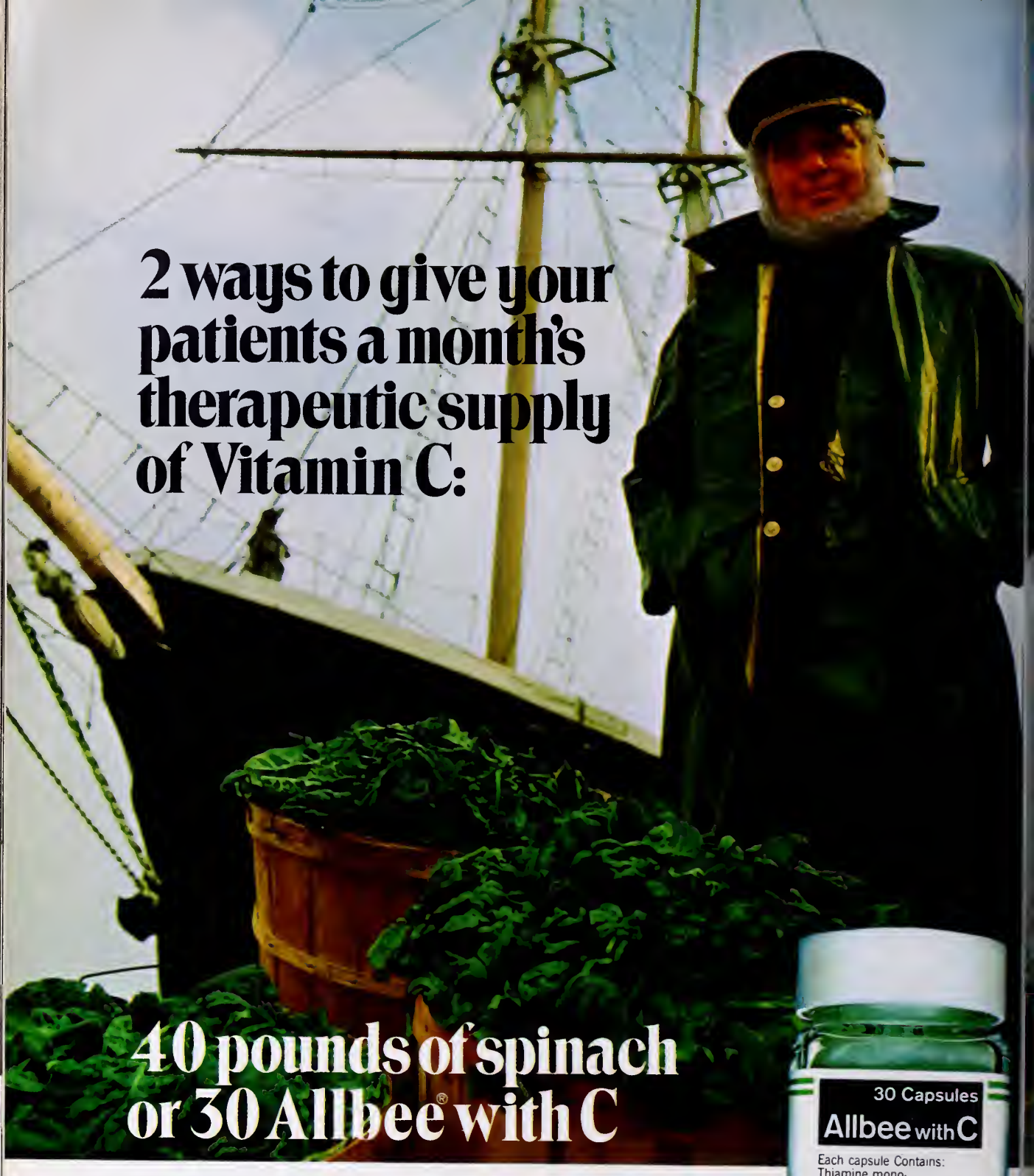
"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

A·H·ROBINS



2 ways to give your patients a month's therapeutic supply of Vitamin C:

40 pounds of spinach or 30 Allbee® with C



Although raw spinach is an excellent source of vitamin C, your patient would have to eat 40 pounds a month (about 1⅓ lbs. a day) to get as much ascorbic acid as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). If the spinach is cooked, a person would have to ingest more than twice as much because cooking destroys much of the vitamin C, and still more is lost when the liquid is drained off. Allbee with C also contains therapeutic amounts of B-complex vitamins. This handy bottle of 30 capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.

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A·H·ROBINS

The girth control pill



Tepanil® Ten-tab

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets One 75 mg tablet daily, swallowed whole, in midmorning (10 a.m.), TEPANIL One 25 mg tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A | 1 | 70 | U S PATENT NO 3,001 910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
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EDITORIALS

What Goes Up Must Come Down

The following editorial is abstracted from one in the June 15, 1970 issue of the *New York State Journal of Medicine*.

Air pollution must be a major health factor because everyone is so mad about it. The politicians, the women's clubs, the "conservation" groups, and college students have elevated the status of environmental pollution to the dizzy heights of the hula-hoop craze. Unfortunately, the seriousness of air pollution deserves not just verbal flux and slogans at the spinal reflex level, but constructive thought and action based on factual information. It is disheartening to attend an anti-pollution meeting and find that some of the most vociferous crusaders are chain smokers who probably would be bewildered if accused of being a major source of air pollution. Yet, few gaseous industrial effluents can match these "romantic" conditions under which as much as 50 milligrams of solid wastes can be inhaled in a ten-minute period and the level of carbon monoxide in the smoke is 400 parts per million or about 20 times higher than an average industrial condition.

In debates and preventive planning it is well to separate the evils of air pollution into groups, since a bad odor does not necessarily cause disease. Thus, one might consider different levels of antisocial consequences: (1) Esthetic effects such as haze and smog, and odors, (2) personal annoyance and nuisance such as dirt and eye irritation, and (3) aggravation of existing pathology and the cause of neodiseases.

The economic losses from air pollution such as damaged clothes, rubber products, and painted surfaces, and injury to plants and trees are not the primary target of public health actions, but cannot be separated from them. This is fortunate since tangible damage of material things can be estimated by a recognizable value scale (seven billion dollars a year), but it is difficult to "price" the inability to see the distant scenery or even the neighbor's picture window.

The adverse effect of air pollution on the general health has been based on several severe episodes of community-wide pollution and specific exposures under industrial conditions, but practically no valid epidemiologic studies and little experimental data are available. Man is such a resilient animal that he can survive prolonged exposure to huge amounts of coal dust and industrial vapors, and in many instances a combination of factors are required before discernible pathology develops. We need more exact studies of people exposed to high levels of pollution in order to learn how to detect minimal alterations of tissues that may reflect the adverse effects of ordinary pollution levels. For example, more studies are needed of traffic directors in tunnels, auto mechanics, roofers, millers, woodworkers, coke plant operators, and such other occupations that reflect major kinds of air pollution. Noxious odors are socially undesirable but it is difficult to prove, or even indirectly implicate them as health hazards. Downwind living by a rendering plant, a glue factory, or even a dairy may cause psychic trauma and adverse social reactions but still we have little data on the "inside man at the skunk works." Is olfactory sensitivity permanently and selectively damaged as is the ear by noise pollution?

Valid epidemiologic studies are difficult to plan and complete because workers exposed to noxious odors have high turnover rates. Similarly, most people living in areas of high air pollution do not stay long and thus the detection and meaningful pathology is difficult. Further, the inhabitants of such areas are also apt to have many social and health problems that make evaluation of the contributory effects of air pollution very complex. Some so-called epidemiologic reports of the effects

of air pollution on health in urban areas are unqualified nonsense.

Air pollution studies have never formed a popular area of medical research since they require long-term experimentation. While industry is a convenient target, it would be well to remember individual responsibility. Cars with 40 or 50 horsepower engines would suffice for most activities. Burning steaks on your outdoor grill is not really a critical activity. Cigarette smoking (let us not kid ourselves) is deadly. As you enjoy a blazing fire in your home hearth, other forms of domestic air pollution may occur to you. What goes up must come down!

The New Transference

In the general hospital field, patients and their families speak with pride of going to a specific hospital or university "medical center." They do not ask who the attending physician is, but rather they boast of the institution and its fame. Again, with the burgeoning of group and team practice, the patient is encouraged to look to the team or group as the object of his loyalty. Individual doctors may come and go but the group or partnership appears to stay forever. In our own field, the development of community mental health centers is building up the same kind of loyalty among psychiatric patients. The records belong to the clinic or to the center, not to the practitioner or to the patient; the doctor is a slot to be filled in by this one or that, and the slot, rather than the person who occupies it, becomes the target of the transference.

It used to be that you could develop rapport only with an individual. But in the modern world, the world of computers, transcribers, team work, and data processing, you develop rapport with the system, the team, the clinic or the center. The Sweetheart of Sigma Chi need be faithful only to the fraternity; in like manner the patient can make his transference to the Center. Perhaps it is really more efficient that way, since, after all, not one of us is indispensable. Perhaps, not.

The Best Of All Possible Drugs

There is some clamor these days for legislation that would ban the patenting of a new drug unless the manufacturer could prove that it was significantly more effective than all similar drugs now available. This well intended, if somewhat naive, proposal is an interesting example of how the plausible can become the mischievous. If such a bill passes, Government will then determine the relative efficacy of each new drug. Similar criteria, one might suppose, would be applied to air conditioners, automobiles, television sets, and cocktails. Let us permit only the best pencils, pickles, or penicillin to be sold.

Only an amateur would suppose that drug efficacy can be determined that simply. If a drug is potent, it is also potentially dangerous. At what point does the danger outweigh the benefit? How does the federal agency allow for personal idiosyncracy of patients? Is a pleasantly flavored vehicle enough to warrant a patent if there is no change in pharmacologic effectiveness? How do you appraise therapeutic efficiency in human beings without trying the drug before it is made available for human use? Do you release it on the basis of animal experiments only? How does a Government tribunal weigh the placebo effect, the suggestive effect, and effect of the practitioner's art on the workings of a new pharmaceutical?

Of course the Federal Government can, by a simple act of Congress, create a Section for the Appraisal of Pharmaceuticals (to be identified by its capital initials), and thus the Voice of Authority will tell us what is good for us. The Voice of Authority once rejected Lister's theory of antisepsis, Jenner's vaccination against small pox, Semmelweiss's report on the cause of puerperal fever — not to mention Auenbrugger's discovery of the value of chest percussion. Federal appraisal of drug efficiency offers a road well paved with good intentions — and fraught with the mischief that often comes when amateurs make technical decisions for the professionally trained.

ORIGINAL ARTICLES

Sweating players and workmen need electrolytic fluid replacement, and Dr. Balakian here suggests a formula.

Action Aid For Athletes*

Balanced Electrolyte Solutions For Prophylaxis Of Heat Illness

Gerard Balakian, M.D./West Englewood

While electrolyte solutions intravenously are old in the practice of medicine, they are new for sports, if given orally and for everyday activities which cause heavy sweating.

The old wives' tale about fluids being bad for actively sweating individuals began some 100 years ago when British miners drank large amounts of water after excessive sweating and developed cramps in the legs. It was not understood then, but actually, the cramps were the result of diluting an already lowered blood sodium. Thus began the taboo on water for sweating individuals. Some 50 years later, when salt chemistry was better understood, irritating salt tablets were given, but the ban on water still held. Hence, sweating individuals were still not given water during strenuous activity.

This was essentially the situation as recently as 1965, when the highest death rate (6 persons), since documentation, occurred from heat stroke in early season football.[1] This quickly opened the investigation on fluid and electrolyte replacement during heavy physical activity, as in sports. Physiologists, like those of the American College of Sports Medicine, showed that both water and salt were needed for the prophylaxis of heat illness. A re-education program for coaches, trainers, athletes, and even physicians became necessary.[2,3] Other investigators gave further evidence of the theoretically known need for potassium in heat stress.[4,5,6,7]

As methods of replenishment came into use, some pertinent questions have been asked, such as:

1. How much electrolyte fluid does the average athlete lose under warm weather conditions? How much can he tolerate under more extreme conditions?

2. Is salt loading and/or water loading a good way of taking care of his needs?

3. Are salt tablets plus water just as good as electrolyte solutions?

4. What should be the essential ingredients of electrolyte solutions?

5. Is potassium really needed in such a solution?

While the answers to these questions are found in the medical literature of recent years and will be referred to here, a simple example of a case study also helps to illustrate some of the answers.

Local Observations and Case Study

Starting in 1965, in local Bergen County high schools where my son played, I watched many practices and games and noted that it was not unusual for a 160 to 180 pound player to lose 3 to 4 pounds during a 90 minute session with pre-season temperatures in the 80's and relative humidity of 50 per cent or higher. Since only about 600 calories per hour is an average loss in football,[8] it became obvious that 85 to 90 per cent of weight loss is due to water loss along with the salts that go out in the sweat and the kidney.**

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* Presented before the World Congress of Sports Medicine, Oxford University, September 6 to 11, 1970.

** Personal Experiences as Advisor to Team Physicians at Englewood School for Boys, Tenafly High School, St. Cecilia High School, Rutgers University, and others (1965-1969)

A series of boys were studied at a usual warm weather practice session of early September at Tenafly High School, and an example of fluid and electrolyte losses in a running left halfback, age 17, weighing 170 pounds is detailed below.

Age 17, 70 inch, 170 pound, left halfback for Tenafly High School observed during hot weather football practice for pre-season, 1967.

Conditions: 90 minute practice, afternoon session, clear skies, no wind, full uniform, 83 degrees F, relative humidity 50 per cent.

Replacement: Only plain water, total one liter in divided 6 ounce servings at short breaks during practice.

Parameters:

	Pre-Practice	*Post-Practice*
1) Weight in lbs & Kg	170 lbs (77.2 Kg)	166 lbs (75.4 Kg)
2) Blood pressure	110/76	110/80
3) Temperature	98.6	98.6
4) Urine volume	60cc	60cc
5) Blood sodium	141 mEq/L	143 mEq/L
6) Blood potassium	3.7 mEq/L	3.9 mEq/L
7) Total protein	7.9	8.2
8) Blood sugar	82 mgs%	100 mgs%
9) Urinary sodium conc.	62 mEq/L	38 mEq/L
10) Urinary potassium conc.	57 mEq/L	70 mEq/L
11) pH	7.34	7.38
12) PCO_2	50	45
13) CO_2	27	27

Calculations to Illustrate Deficits from Practice Session

SODIUM

1) Starting pre-practice weight:
170 lbs or 170/2.2 = 77.2 Kg.

2) Weight converted to Extracellular Fluid which is 20% body weight:
77.2 × .20 = 15.4 Liters E.C.F.

3) Pre-practice blood sodium level = 141 mEq/L

4) Total E.C.F. pre-practice sodium would be:
141 × 15.4 = 2171 mEq sodium.

5) Weight change: Pre-practice: 170 lbs or 77.2 Kg.
Post-practice: 166 lbs or 75.4 Kg.
4 lbs or 1.8 Kg.

6) Calories used: in 90 minutes of football practice at 10 calories/minute = 900C. Using carbohydrate yield of 4 calories/gram: 900/4 = 225 grams lost. With a 1.8 Kg. weight loss, 225 grams are solid matter or about 13% of the total loss. This leaves about 87% as fluid loss.

7) Fluid weight loss—as a result of practice:
1.8 Kg. × .87 = 1.6 Liters.

8) Post-practice Extracellular Fluid calculation:
Pre-practice E.C.F. was 15.4 Liters
E.C.F. loss from pract. — 1.6 Liters
Post-practice E.C.F.: 13.8 Liters

9) Post-practice blood sodium: 143 mEq/L

10) Total post-practice E.C.F. sodium would be:
143 × 13.8 = 1973 mEq sodium.

11) Post-practice Total E.C.F. sodium deficit:
Total pre-practice Na = 2171 mEq
Total post-pract. Na = —1973 mEq
Total Sodium deficit: 198 mEq

POTASSIUM

1) Pre-practice Total E.C.F. Potassium:
Pre-practice potassium blood level:
3.7 mEq/L × 15.4 Liters (pre-prac. E.C.F.)
= 57 mEq Total E.C.F. K^+

2) Post-practice Total E.C.F. Potassium:
Post-practice potassium blood level:
3.9 mEq/L × 13.8 L (post-practice E.C.F.)
= 53.8 mEq Total E.C.F. K^+

3) Post-practice potassium deficit in total E.C.F.:
Pre-practice total E.C.F. potassium: 57.0 mEq
Post-practice total E.C.F. potassium: —53.8 mEq
Total Post-practice potassium deficit: 3.2 mEq

URINARY FINDINGS

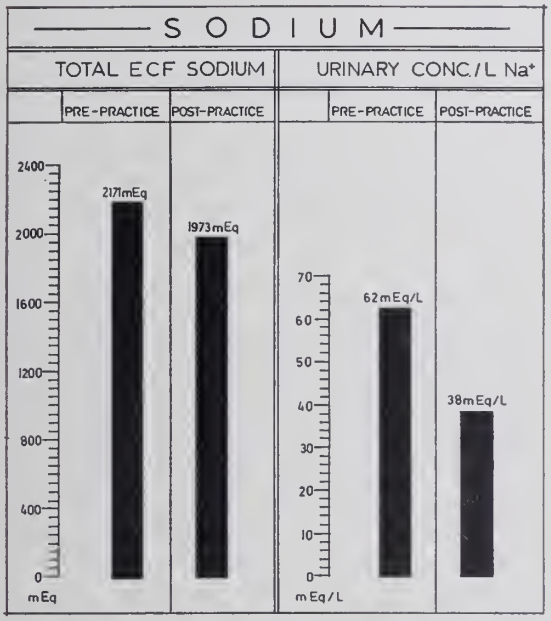
Sodium: Pre-practice: 62 mEq/L
Post-practice: 38 mEq/L
24 mEq/L
Represents drop in post practice urinary sodium concentration

Potassium: Post-practice: 70 mEq/L
Pre-practice: 57 mEq/L
13 mEq/L
Represents rise in post practice urinary potassium concentration

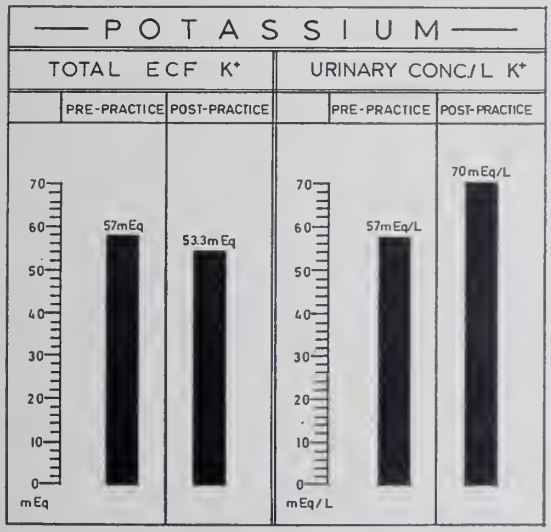
These laboratory studies were done at the Englewood Hospital Laboratory on the day specimens were drawn. They were done under the supervision of S. Raymond Gambino, M.D., then Director of Laboratories of Englewood Hospital. The daily quality controls for sodium and potassium were up to one per cent.

The chart shows that despite an intake of a full liter of plain water, taken in divided 6 ounce servings, his weight dropped from 170 pounds to 166. Our calculations show that by taking 20 per cent of his beginning body weight in kilograms, we obtain a beginning extracellular fluid of 15.4 liters. By multiplying his total extracellular fluid of 15.4 liters by his beginning blood sodium concentrations of 141 mEq/L, we obtain a total extracellular fluid sodium of 2171 mEq before his practice. Post-practice weight of 166 pounds (75.4 Kg.) shows a 1.8 Kg. drop in weight. If we assume

that 87 per cent of this body weight loss is fluid loss (based on calorie dissipation in football of 90 minutes), this leaves 1.6 liters as fluid loss. When this is deducted from the pre-practice extracellular fluid of 15.4 liters, it leaves a now contracted post-practice extracellular fluid space of 13.8 liters. While his post-practice blood sodium was 143 mEq/L, (having gone up because of hemoconcentration), his total new E.C.F. sodium drops when this concentration is multiplied by the contracted volume and gives a total E.C.F. sodium figure of 1973 mEq.



Graphic representation of total extracellular fluid and urinary concentration changes of sodium, pre and post 90 minute football practice, Tenafly (NJ) High School, temperature 83F, relative humidity 50 per cent, full uniform, clear afternoon, 17-year-old running left halfback, pre-practice weight 170 pounds, post-practice weight 166 pounds.



Graphic representation of total extracellular fluid and urinary concentration changes of potassium, pre and post 90 minute football practice, Tenafly (NJ) High School, temperature 83F, relative humidity 50 per cent, full uniform, clear afternoon, 17-year-old running left halfback, pre-practice weight 170 pounds, post-practice weight 166 pounds.

Deficits

The new total extracellular fluid sodium thus shows a drop from a pre-practice level of 2171 mEq to a post-practice level of 1973 mEq or a deficit of 198 milliequivalents of sodium which resulted from the practice. It is also interesting to note that his urinary sodium concentration dropped from a pre-practice level of 62 mEq/L to a post-practice level of 38 mEq/L while the urine volume kept about the same. This would tend to show the kidney's desire to conserve sodium to counteract the large sweat losses.

During the same period, his blood potassium went from a 3.7 mEq/L giving a total of 57 mEq in his 15.4 liter E.C.F. to a 3.9 mEq/L or a total of 53.8 mEq of potassium in his post-practice E.C.F. volume of 13.8 liters. showing a deficit of 3.2 mEq as a result of the practice. At the same time, his urinary potassium went from 57 mEq/L up to 70 mEq/L showing the expected aldosterone effect of increased potassium excretion during the stressful period of the practice session. This would be an increase of 13 mEq/L in the potassium level of the urine. It would appear reasonable to assume that the increased renal losses, the total extracellular deficit (3.2 mEq) and the sweat losses (average 10 mEq/L) are met by a cellular outflow of potassium where the chief depot of potassium lies.[9] Unfortunately, more complex methods of measuring cellular potassium changes are needed.

Comment

The illustration of electrolyte changes in a 90 minute "hot climate" football practice session is intended to show the mechanisms

of changes taking place in the body fluids. These are only rough approximations. Because of the necessary multiplications, we know that the figures are not absolutely exact, but they do show certain basic trends taking place in body physiology during strenuous activity. They also show that while blood concentrations of sodium and potassium go up after exercise due to hemoconcentration, total E.C. fluid stores of these elements go down even with a 4 pound weight loss.

With a theoretical sodium deficit of 198 mEq along with a 1.6 liter fluid loss (and a 2.6 liter potential loss, had a liter of water not been given), one would tend to conclude that this player had a good deal higher than average sweat concentration of sodium (average being 45-50 mEq/L).[10] Hence, he would be a somewhat greater than average loser of salt and water.

This boy started with a slightly low blood potassium of 3.7 mEq/L which may well have been the result of depletion in prior days of practice. Undoubtedly, the total post-practice deficit of only 3.2 mEq in the extracellular fluid does not reflect the true total body potassium which is chiefly in the cells.

We would not expect each player to react exactly the same way as this player did—under similar conditions.[11] A detailed testing program would best have each player act as his own control under similar conditions to show the differences both with and without replenishment of fluids and electrolytes. In general, sodium concentrations tend to drop in the urine while potassium concentrations tend to rise. This is clearly what one would expect with the stress mechanism which provokes aldosterone secretion from the adrenal cortex.[11]

Volume and Method of Replacement

A player like this would have actually lost 6 pounds instead of 4 pounds if he had not taken 1 liter of water and thus require 2.3 liters on a perfect 87 per cent replacement basis. More "average" players tend to lose less. It was more common for average players to lose about 3 to 4 pounds in similar type of practice session (see weight charts) and they would require 87 per cent of 1.4 to 1.8 liters or 1.2 to 1.7 liters per session for perfect replacement. Investigators at the Ohio State University[3] have shown comparable weight losses relative to the higher weights of college football players during warm weather workouts.

How well can a healthy young athlete withstand higher losses of 3 to 5 liters of electrolyte fluid under more extreme conditions of weather in a 60 to 90 minute session? Most authorities[1] feel that losing an excess of 3 per cent of the body weight definitely endangers the possibility of heat illness. Best and Taylor[14] say that heat exhaustion frankly occurs when the body loses about 5 per cent of the body weight. This would be about 5 liters in a 200 pounder.

Weight Changes in Eight Players on Day of Study
(adding weight of 1 liter fluid taken)

Position	Weight: Pre-practice	Weight: Post-practice	Loss
R.H.B.	160	156	4 lbs.
R.E.	161½	158	3½ lbs.
R.T.	193	188	5 lbs.
R.G.	165¾	162	3¾ lbs.
L.H.B.	170	164	6 lbs.
L.E.	150	147	3 lbs.
L.T.	198¼	195	3 lbs.
L.G.	157½	154½	3 lbs.
		Total of 8 players:	31.5 lbs.
		Average weight loss per man (of which about 87 per cent is fluid)	3.93 lbs.

Examples of Conversion of Body Weight Loss to Water Loss:

At 3 lb weight loss: $\frac{3 \text{ lbs}}{2.2 \text{ kg}} = 1.4 \text{ kg} \times 87\% = 1.2\text{L}$ fluid replacement

At 4 lb weight loss: $\frac{4 \text{ lbs}}{2.2 \text{ kg}} = 1.8 \text{ kg} \times 87\% = 1.7\text{L}$ fluid replacement

It is easy to replace fluids and electrolytes in a pleasant way, using commercial solutions now available. It would seem wise to replace them for all prophylactically and not wait for heat illness to occur. At the same time, thirst is quenched and the players feel subjectively better.**

** Personal Experiences as Advisor to Team Physicians at Englewood School for Boys, Tenafly High School, St. Cecilia High School, Rutgers University, and others (1965-1969)

It appears logical to spread this replacement gradually as the session progresses and as the fluid is being lost, thus not overloading the stomach at any one time. We found the six ounce serving a very practical one, though it could be exceeded if necessary. Convenient serving times are: just before a session, midway, and near the end of a session. On hot days when more fluids are necessary, an additional 2 to 3 breaks can be spaced in between these. The "Igloo" type of dispensor was found to be a good way to keep such a drink on the field and individual paper cups placed in a rack were the most sanitary way to give it to the players. Pre-filling the cups saved a good deal of time and ice cubes in the drink improved the taste and also helped keep the overheated body cooler. A powdered salt mix for dilution with water was found to be both economical and space saving, and the inclusion of sodium benzoate aided greatly in bacteriostasis.**

Many wonder why salt tablets plus water might not be just as good as electrolyte solutions for this purpose. It has been the experience of all those who have worked with athletes, (as in the case of sweating servicemen and industrial workers) that plain salt tablets are irritating to the stomach. Coated salt tablets are poorly absorbed from the gastrointestinal tract.[3, 12, 13] We have found that the tense empty stomach of the athlete is especially prone to upset, so that a bland (balanced) salt solution† appears to be the best answer.**

How about advance overloading with either water or salts? This offers no advantage because the body's maintenance of homeostasis will get rid of excesses before they are needed.[15,16]

Balanced Solutions

Of the basic necessary ingredients of such an electrolyte solution, sodium chloride in a non-irritating yet adequate concentration would, of course, be essential. While sweat concentrations of sodium, (and chloride), may go as high as 100 mEq/L, average figures of 45 to 50 mEq/L are commonly given.[10] Stomach irritation and non-palatability even here prevent the use of sodium chloride solutions in excess of 25 to 30 mEq/L, so that this concentration has often been used.[1,2d,3,**] Fortunately also, in many instances, acclimatization will cut the sodium chloride concentrations down to near replacement levels of 25 to 30 mEq/L[11] and such a solution is helpful.** Potassium has been shown to be an important element in the prophylaxis of heat illness and its various gradations. Muscular weakness seen in heat illness results from the excessive loss of intracellular potassium which is drawn from the cells into the extracellular fluid compartment to compensate for the loss of sodium in the sweat.[4,5,6,7] In addition to the usual losses of potassium in the sweat, the body's attempt to conserve sodium and lose potassium under the influence of corticoids and aldosterone is well documented.[10] Electrolyte studies on sweating individuals and even in those with heat illness will not always show the true picture of depletion because hemoconcentration elevates serum levels.[7] Statland[10] tells us that stress of any kind augments potassium excretion by the kidney, both coming from the tissue cells and as a result of sodium retention induced by adrenal responses. The latter leads to more potassium loss.

Hemoconcentration following exercise often gives misleadingly elevated serum potassium levels. We do not have an adequate answer as to how much potassium is needed. Adequate cellular potassium studies are not available on sweating individuals, so that one has to interpolate on how much is needed. One might start with an average sweat loss figure of 10 mEq/L as a baseline for loss replacement.[9] Studies in hot climates have also shown that the increase of salt intake for the prophylaxis of heat illness increases potassium excretion.[17] Furthermore, a majority of cases of heat stroke in a large series have shown potassium depletion in the serum.[18]

†Sportade® powder mix in solution (Becton-Dickinson) was used. This was formulated and named by the author.

** Personal Experiences as Advisor to Team Physicians at Englewood School for Boys, Tenafly High School, St. Cecilia High School, Rutgers University and others (1965-1969)

Considering these factors, it would not seem illogical to add about 40 to 100 per cent of our average sweat loss figure of 10 mEq/L of potassium as a prophylaxis against heat illness. This would be somewhere in the range of 14 to 20 mEq/L of potassium to take care of both sweat and cellular losses via the kidney. This amount is no greater than the potassium in 16 ounces of orange juice and is completely safe when given in a bland palatable salt of potassium.

The use of both quick acting and intermediate acting carbohydrates for palatability and caloric replacement also appear to be an important part of a well balanced oral electrolyte solution.**

Summary

Early season football deaths in 1965 due to heat stroke demonstrated the need for and gave rise to the prophylactic use of balanced electrolyte solutions against heat illness. A simple illustration is given showing extracellular and renal electrolyte changes following a warm weather practice session of a New Jersey high school football player, showing how deficits can occur. These findings are borne out largely by the medical literature on heat stress in recent years. It appears wise to replace combined fluids and electrolytes gradually in proper proportions without overloading or irritating the stomach. Such measures should keep our sweating athletes and other active people in good condition during performance and prevent the hazards of heat illness.

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141 Ayers Court

** Personal Experiences as Advisor to Team Physicians at Englewood School for Boys, Tenafly High School, St. Cecilia High School, Rutgers University and others (1965-1969)

Paravesical hemangioma is rarely suspected and almost never reported. Here, however, is one of these rare cases.

Primary Paravesical Hemangioma*

Anthony R. Fernicola, M.D./Newark

A tumor in the paravesical space of the female is apparently very rare and is difficult to delimit clinically. The paravesical "space" is extraperitoneal and is virtually obliterated in the region of vesicoperitoneal contiguity. A tumor which arises independently at this site is presumably of connective tissue or of embryonic anlage. A survey of the literature discloses no evidence of a case wherein the topography of such a tumor mass is cited.

The purpose of this report is to illustrate the characteristics of a primary tumor which develops in the paravesical space and to present the diagnostic pitfalls encountered in an attempt to specify the location of an extraperitoneal tumor mass in juxtaposition to the urinary bladder.

A 36 year old female was admitted to the gynecological service of Columbus Hospital on June 19, 1957, she had enjoyed good health until six months prior to admission when she experienced recurrent, "crampy" lower abdominal pain. She had occasional dizziness. Her symptoms were unrelated to the menses which lasted five to six days. Menstrual periods were irregular and painful. She married at age 24 and had had no pregnancies. Review of systems disclosed no significant data other than appendectomy at age 13.

She was a well-developed, well-nourished woman in apparent good health. A smooth, firm, tender, movable visible mass occupied the right lower quadrant of the abdomen. Bimanual examination substantiated the presence of a large, ballotable mass which was not distinguishable within the pelvic cavity. Laboratory findings were within normal limits.

A presumptive diagnosis of uterine fibroid was made. Operation revealed the uterus and adnexa to be normal. A large extraperitoneal mass was encountered presumably of bladder origin. The abdomen was closed inasmuch as urologic evaluation was considered necessary for definitive management.

Intravenous urogram showed no abnormality of kidney structure, function or drainage. The course and structure of the ureters were normal. A large, soft-tissue mass containing calcifications compressed the greater portion of the right lateral wall of the bladder (figures 1-A and 1-B). Cystoscopy disclosed no intrinsic bladder abnormalities. Considerable extrinsic pressure was present on the right lateral and posterior walls of the bladder. The mucosa was preserved. The ureteral orifices were normal. A number 5 French ureteral catheter was passel 26 centimeters to the right kidney pelvis without obstruction. X-rays in the antero-posterior and oblique views with the ureteral catheter in place showed no ureteral displacement.

On July 5, 1967 a second operation was performed through a right Gibson incision. A solid, round tumor, the size of a large grapefruit was seen. Surface of the tumor was smooth, vascular, bluish-red and encapsulated. The tumor was bounded inferiorally and



Figure 1-A

*From the Columbus Hospital, Newark, New Jersey, where Dr. Fernicola is consultant in urology.



Figure 1-B

Figures 1-A and 1-B—The intravenous urogram reveals considerable compression of the urinary bladder by a large, soft-tissue mass containing calcifications.

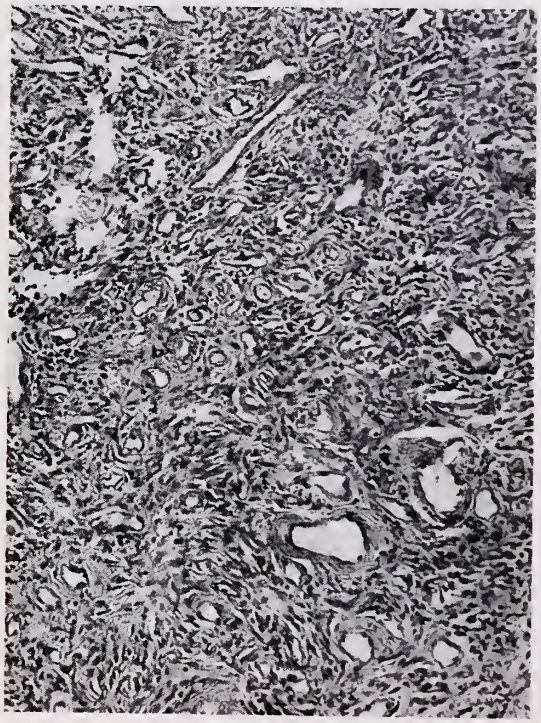


Figure 2-A—Low power magnification. Numerous vascular channels surrounded by proliferation of endothelial cells.

medially by the bladder and superiorally by the peritoneum. The mass was mobilized by blunt dissection with slight difficulty and removed. The postoperative course was uneventful and the patient was

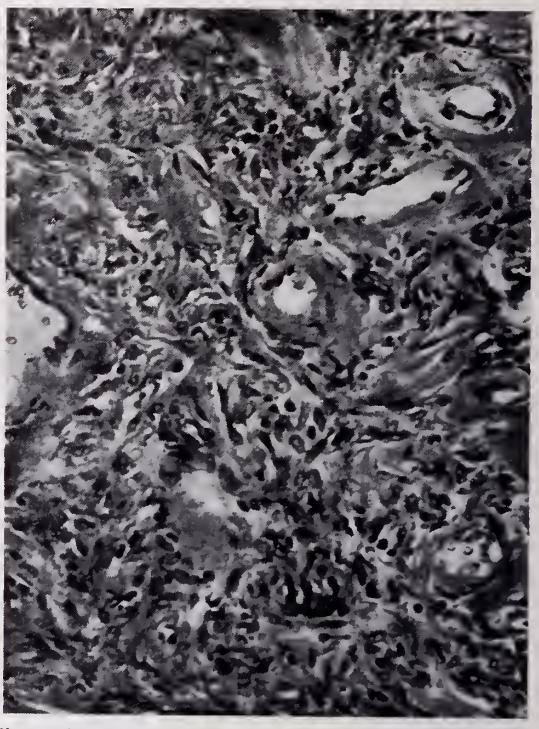


Figure 2-B—High power magnification. Numerous vascular channels with overgrowth of endothelial cells possessing large, irregular, hyperchromatic nuclei. Patches of acellular hyalinized connective tissue stroma present.



Figure 3—The intravenous urogram taken twelve years postoperatively is normal.

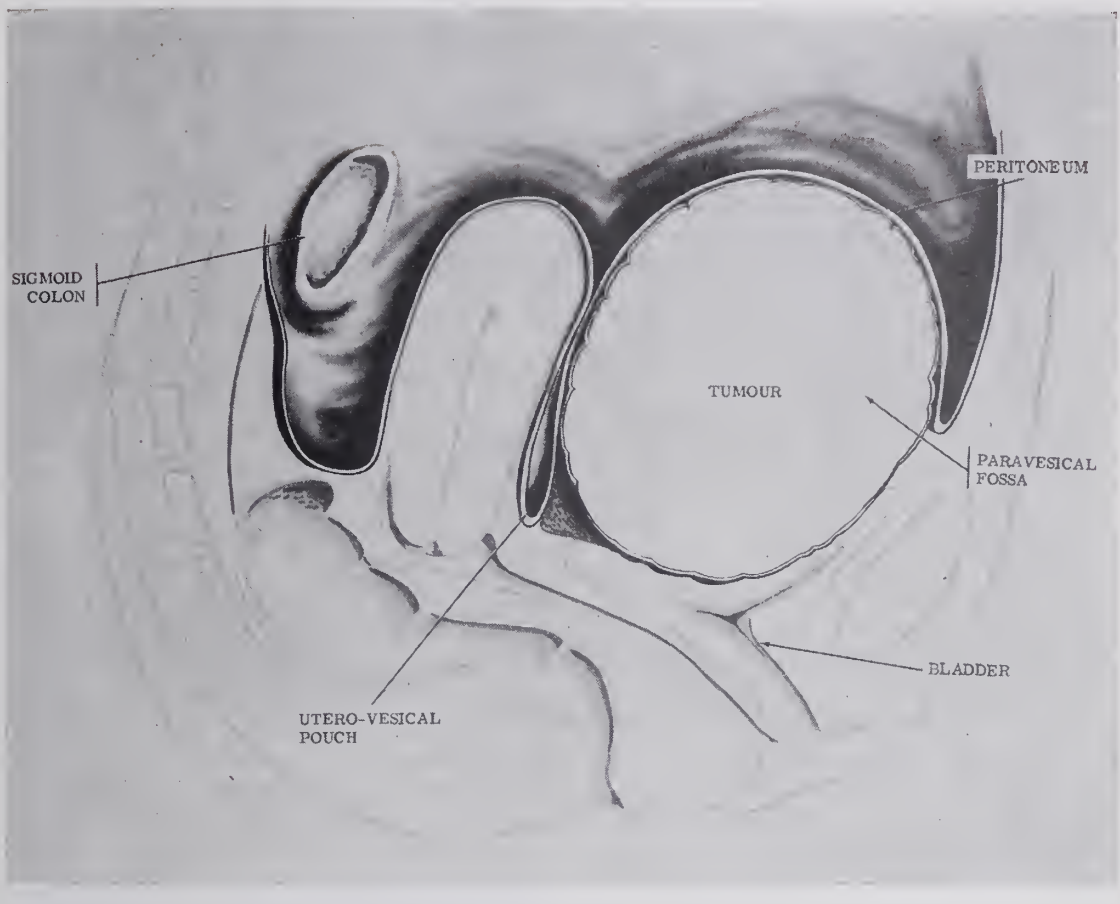


Figure 4—Diagrammatic representation of displacement of urinary bladder and elevation of parietal peritoneum by expanding tumor arising in the paravesical space.

discharged on the ninth post-operative day. The pathologic diagnosis (Dr. Edwin H. Albano) was hemangioendothelioma (figures 2-A and 2-B).

Within one year following the removal of the tumor the patient became pregnant for the first time. On September 15, she was delivered of a normal baby. The most recent intravenous urogram taken on September 15, 1969 was normal (fig. 3). At this time, 13 years post-operatively, examination revealed no abnormalities. She appeared in good health.

No apparent clinical feature distinguishes a tumor in the paravesical space of the female. The presence of a paravesical mass is hardly suspected irrespective of its palpable and visible dimensions. Accordingly, refined diagnostic measures are not contemplated. Operation for a presumable uterine or ovarian mass is ordinarily instituted. The value of angiography and pelvic pneumography in such a case is indeterminable.

Tumor growth in the paravesical cavity expands the potential space in the region of contiguity of peritoneum and bladder. Elevation of the peritoneum and separation of the peritoneal reflection from the bladder occur. Displacement of peritoneal contents and bladder are the predominant effects of an expanding tumor in the paravesical space which is partially enclosed by bony pelvis (figure 4).

Displacement of the bladder by an interligamentous fibroid or an intraligamentary cyst is roentgenographically indistinguishable from the bladder displacement produced by a primary paravesical tumor. Presacral tumors, perivesical abcess and fecal impaction may displace the urinary bladder.†

†Ney, C. and Friedenberg, R. M.: *Radiographic Atlas of the Genitourinary System*, p. 485. Philadelphia, 1966, Lippincott.

Summary

A primary tumor arising in the paravesical space is described. The tumor in this patient was hemangioendothelioma. Within one year following the removal of the tumor the patient became pregnant for the first time after twelve years of marriage. Her pregnancy was uneventful. She was delivered of a normal boy. Suspicion of a paravesical tumor in the female is remote inasmuch as its clinical characteristics are indistinct. The roentgen finding of bladder displacement produced by an expanding primary paravesical tumor is indistinguishable from the roentgen signs produced by tumors of the internal genitalia.

402 Mt. Prospect Avenue

Research Into Sudden Death

The National Heart and Lung Institute has awarded contracts for research on sudden cardiac death. Sudden cardiac death. or death before hospitalization, accounts for about one-half of the almost 600,000 annual deaths from arterio-sclerotic heart disease. While an improvement in the early availability of medical care will somewhat reduce this death toll, the large number of very sudden and very early deaths necessitates a better understanding of the acute disease process, and the development of new modes of therapy.

The contractors for the first year are: the University of Miami, Johns Hopkins University, Mount Zion Medical Center of San Francisco, and Emory University in Atlanta.

These contracts are designed to identify "trigger" factors that convert coronary atherosclerosis, the underlying disease process which may have been quietly present for many years, into a full-blown attack, and to identify premonitory signs and symptoms that may warn the patient or his physician of an impending attack. It is hoped to identify factors that characterize the person at high risk of sudden, unexpected death. Studies have quantified many of the factors which increase susceptibility to coronary heart disease, including high blood pressure, elevated blood lipids, cigarette smoking, obesity, electrocardiographic abnormalities, and sedentary habits. It may be possible to refine this "coronary profile" and to recognize other factors to identify prime candidates for rapidly lethal heart attacks. It is also hoped to identify mechanisms responsible for acute heart attack and sudden death and to correlate them with anatomical and pathological changes. This research may also determine practical methods of treatment for the very early stages of a heart attack.

A major facet of these contracts is the collaborative study of correlations between autopsy findings and antecedent events in sudden cardiac death victims. The four contracts all provide for a common core of autopsy and interview data.

Interviews of family, physicians, and witnesses of the attack will include information of long term historical items, but will focus on the events immediately surrounding the acute illness. Each acute event will be carefully examined to determine the exact circumstances, symptoms, and activities of these victims at the time of an attack and in the preceding hours and days. The information will be recorded in a standardized fashion and will be systematically analyzed for possible clues to premonitory symptoms, precipitating factors, and early physiological mechanisms.

The combination of surgical treatment and radiology has proved to be remarkably effective in treatment of carcinoma of the head and neck.

Combined Therapy Of Carcinoma Of The Head And Neck

Herbert J. Deutsch, M.D./Cherry Hill

Extensive tumors of the head and neck respond poorly to surgical treatment or radiation treatment alone. In recent years, a combination of both modalities has significantly improved patient survival. Goldman and Friedman[1] treated extensive laryngeal neoplasms with combined therapy for a ten year period. In their series, the five year survival increased from the usual range of 20 per cent or less to a determinate survival of 83 per cent. Leonard, *et al.*,[2] combined radiation and surgical therapy of the tongue, tonsil, and floor of the mouth and found a marked improvement in survival.



Figure I

A fifty-five year old male who presented with a huge carcinoma of the gingiva extending onto the floor of the mouth, retromolar area and maxillary alveolus. Patient was treated with 5,500 rads of cobalt radiotherapy and six weeks later I performed a combined resection of the entire original tumor site with a wide cuff of normal tissue and radical neck dissection. A muscle pedicle flap of Levator scapulae muscle was used to cover the carotid artery. The superior portion of the skin flap was sutured tightly to prevent dissection of the saliva under the flaps. Postoperatively, necrosis of the superior portion of the posterior skin flap slowly progressed and a salivary fistula developed. The first photograph shows the salivary fistula and maximum extent of the skin flap necrosis.

The most impressive results in the treatment of head and neck tumors have been with the use of full cancericidal doses of radiotherapy in the range of 4,000 to 5,500 rads followed in about six weeks by a wide radical resection of the primary tumor.

Radiation physiologists[3] determined that 5,500 rads will have a lethal effect on tumor cells and tumor doses above that level may not cause a commensurate increase in survival. In addition, experience has shown that radiation levels above 5,500 rads result in significant increases in the operative mortality and morbidity. Therefore, the range of 4,500 to 5,500 rads was arbitrarily determined as the highest permissible level of preoperative radiation.

High dosage preoperative radiation has not been widely accepted because of increased



Figure II

After the area of necrosis had demarcated, I utilized a nape of the neck pedicle skin graft to close the salivary fistula.

postoperative morbidity and mortality. Radiation impairs postoperative healing, causes tissue edema and fibrosis, and makes the surgical procedure more difficult. Tissue resistance to infection is lower and complications are increased. Patients develop salivary fistulae, necrosis of the skin flaps, rupture of the carotid and other arteries, and osteoradionecrosis of the mandible and other involved bone tissue.

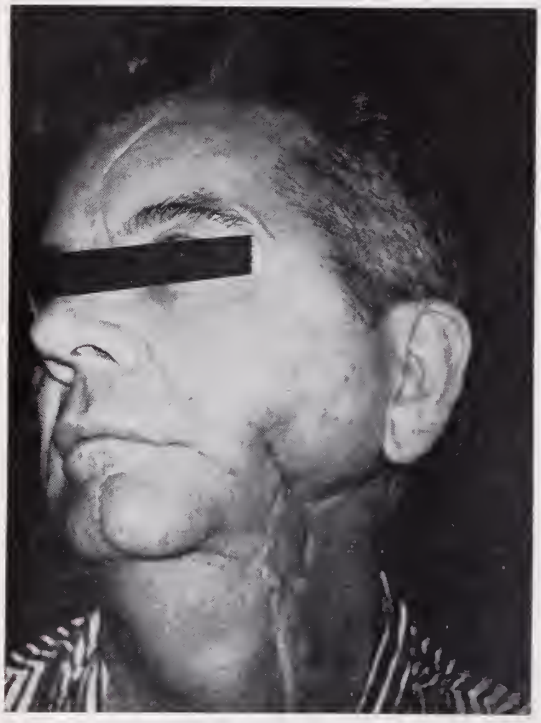


Figure III

The skin flap has been replaced and healing completed.



Figure IV

Patient was a twenty-two year old male with an extensive neoplasm of the maxillary sinus, ethmoid sinuses, and orbit. Patient was treated with 5,500 rads tumor dose of cobalt radiotherapy, followed in six weeks by radical maxillo-ethmoidectomy and orbital exenteration. No complications ensued. The maxillary skin grafts took completely and the operative incisions healed primarily without necrosis or scarring.



Figure V

Patient was a fifty-five year old male who presented with a huge carcinoma of the epiglottis and vocal cords with cervical metastases. Patient received 5,500 rads cobalt radiotherapy followed in six weeks by radical neck dissection and laryngectomy and three months later by a contralateral radical neck dissection. The skin flaps healed primarily without necrosis, salivary fistula, or other complications.

In recent years, improved surgical methods plus better postoperative care have decreased postoperative mortality and morbidity to a low and acceptable level. Flaps are designed to give maximum blood supply, to limit necrosis and to cover major arteries. Suture lines are carefully approximated and reinforced to prevent breakdown and fistulae. Blood vessels are covered with muscle flaps and dermal grafts to prevent carotid rupture.

Surgical Treatment

The extent of the primary tumor must be carefully recorded prior to radiation and the surgical procedure should include the entire primary site and adjacent normal tissue. Radiation therapy may shrink the tumor or cause it to disappear, but this is not an indication for decreasing the extent of the surgical resection. For maximal survival, the original tumor bearing area must be included in the resection. When the latter is not carried out, the neoplasm is likely to recur at the original site.

Without preoperative radiation, surgical resection of the large tumor may be impossible.

When the resection is accomplished, a very narrow margin of normal tissue is included with the specimen. As a result, local recurrence and regional metastasis are frequent. Radiation therapy usually shrinks the primary tumor and cervical nodes significantly so that the tumor becomes readily resectable.

Variations of Radiation Therapy

During the past thirty years, many methods of combined therapy have been used without significant improvement in the survival rate. Postoperative radiation was used frequently to eradicate unresectable neoplasms, sterilize potentially seeded areas, or as prophylactic treatment. In most series, results were not impressive and this method of treatment had limited application. Possibly, the decreased blood supply and oxygenation in the operated area had decreased the effectiveness of the radiation treatment. In some cases, resection through the tumor site may have resulted in distant hematogenous or lymphatic spread. Sandwich therapy in the form of low dosage pre- and postoperative radiation had considerable acceptance for several years but the results were equivocal and at present, this method has very limited use.

Low dosage preoperative radiotherapy has been utilized in recent years. In some cases 1,200 rads were administered shortly before surgery and in others 2,500 rads are given several weeks before surgery. Some results are significant and others equivocal, but for the most part, the statistics are too limited for a critical evaluation at this time.

Survival Rates

Goldman and Friedman[1] reported 53 cases of advanced laryngopharyngeal tumors, classified as Stage III of the International Classification or Stage II ($T_2 N_0$ excluded), III, or IV of the classification of the American Joint Committee for Cancer Staging and end result reporting. Two thirds of the patients have palpable cervical metastases. They reported a five year survival rate of 74 per cent absolute and 83 per cent determinate. The two year survival rate has been 88 per cent absolute and 97 per cent determinate.

Leonard *et al.*[2] treated eight cases of carcinoma of the anterior two thirds of the tongue, all of which were greater than two centimeters in diameter. All were alive and well one to five years after treatment. Eighteen patients with carcinoma of the tonsil were treated and fourteen were alive and well, one to four years following treatment. Five patients with carcinoma of the floor of the mouth were treated and four were alive and well one to five years post treatment. The study included similar patients treated with surgery or radiation alone and the results were significantly lower.

Comment

Combined therapy appears to be a major advance in the treatment of extensive head and neck neoplasms. The statistics show an unprecedented increase in survival rates which is unequaled by any other mode of treatment. Improved surgical and post operative technics have limited the post operative morbidity and mortality so that possible complications are no longer a deterrent to this form of treatment.

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905 Kings Highway

Discography is here found useful in determining pathology in the cervical spine.

Discography, Myelography, And Interbody Fusions For Cervical Syndrome

Marvin Chirls, M.D./East Orange

This report presents the results of treatment of types of cervical disc syndromes over a 10 year period ending in January 1970.

Three hundred patients were treated for cervical disc syndrome with 250 of the patients being operated upon. Two hundred were followed with questionnaires. Of these, 162 were operated patients and 38 were not.

Patients were classified into traumatic and atraumatic groups in order to assign patients with degenerative changes to a separate category. No patients in the traumatic group (with the exception of fracture-dislocations) were operated upon in less than six months from the time of the original trauma. Patients were not specifically categorized into liability or non-liability cases.

Classification of Pathology: (1) Soft cervical disc; (2) Spondylosis with degenerative discs; (3) Fracture-dislocations with or without disc protrusion.

Specific Levels: C3-4, 2 cases; C4-5, 23 cases; C5-6, 65 cases; C6-7, 45 cases; C7-T1, one case; multiple levels, 26 cases. In one case, it is felt that the wrong level was fused but the patient refused further surgery.

Clinical Syndrome: The typical patient complained at one time or another of headaches, pain in the neck, dysphagia, pain in both shoulders and trigger points in the trapezius muscle. Patients with lower cervical lesions reported pain in the axilla or in the upper extremity. Patients with lesions at the C3, C4, or C4-5 did *not* complain of numbness or tingling in the fingers. Three patients were referred after having been thought to have myocardial infarctions. Seven had previously consulted psychiatrists for their symptoms.

Findings: We noted, contrary to general belief, that 20 per cent of patients had no positive physical findings. All had symptomatic but no neurological deficit, atrophy, or weakness. All patients had cervical spine x-rays. Here nothing was proved except for some showing degenerative changes and osteophyte formation. Twenty-three per cent of all x-rays were normal.

Cervical myelography was done on all patients and was positive in 65 per cent of the cases. The myelography did not determine the level of surgery as accurately as discography and, when negative, did not add anything to the indication for further treatment. Myelography is necessary to evaluate soft discs and posterior hypertrophy of bone and ligamentum flavum resulting in osteopathic myelopathy. One must perform myelography to determine whether or not the approach should be strictly anterior, posterior, or a combination of both.

Cervical Discography: Over the past decade, I have felt that this is essential as part of one's diagnostic armamentarium to determine localized pathology in indicated cases. The "two

needle" technic, as described by Cloward[1] is used. Under local anesthesia, a 20 gauge needle is inserted into the disc space and a 24 gauge needle placed through the original needle. Injection of radio-opaque material (Renographin 60) is then performed in all cases. In all patients multiple levels were done. All patients were warned that they would have some discomfort and that the purpose of the examination was to determine where the discomfort was. When one places the original 20 gauge needle into the anterior aspect of the annulus or the anterior longitudinal ligament, pain is referred posteriorly into the shoulder blades, the neck and occiput depending upon the level at which the needle is inserted. This usually guides the examiner to the specific level of previous complaints of the patient. Once the level of the needle is localized, using an image intensifier and x-rays, a small amount of dye, usually measuring between 0.1 to 1 cubic centimeter, is injected. As soon as the patient begins to complain of pain, the injection is stopped. Discomfort is then considerably decreased. Bi-plane x-rays are taken immediately in order to show any extravasation of dye out of the disc space. Remember that degeneration of the cervical discs begins during childhood and that one can have a degenerated disc without symptoms. Asymptomatic abnormal discs caused the patient much less pain under examination than those which were symptomatic. All pain from the injection of the disc subsided within a few minutes following the procedure. It was not found necessary to inject the disc with a local anesthetic. When multiple disc levels were done, the lower disc was always injected first. This causes less interference on x-rays with dye flowing caudally.

The purpose of discography is to indicate that pathology does exist in cases of negative myelography and normal cervical spine x-rays. When there was a tear of the annulus, this could not be demonstrated on the myelogram and could be proved only with discography. Without discography, it was impossible to determine the specific level (or even the etiology) of pain. There were no complications from cervical discography in the form of diskitis or persistent pain. With unstable dislocations and without disc protrusion, discography determined the pathology when all other examinations were within normal limits. It appears to me that occult neck injury can be diagnosed with early discography.[2]

X-rays of the cervical spine were taken in flexion and extension in all cases to determine whether there was any abnormality of motion at any level. It was felt that this could not be determined however, and the examination was disregarded in the series.

Surgery: 250 patients were operated upon and of these, 162 were followed for a period of one to ten years. All patients were operated upon in the supine position with a Sayre sling attached for traction. A transverse skin incision was made at the approximate level to be fused and the platysma incised in the same line. Using blunt dissection, an approach was made down to the anterior aspect of the spine with the neuro-vascular bundle lateral and the trachea, esophagus, and thyroid medial. To identify the esophagus, a Levin tube was passed pre-operatively in all patients. This was removed immediately following surgical closure. A needle was used to identify the proper level by x-rays in the operating room. Once the level was determined, the entire disc was removed by means of the Cloward technic.[1]

Complications: In two patients post-operatively, there was increased kyphosis with settling of the graft anteriorly. One patient had three levels fused and another had one level fused. In the patient with one level, a post-operative myelogram was done after six months and the defect was found to be relatively large but the patient was asymptomatic. Four patients had recurrent laryngeal nerve palsy, and in all of these normal function returned within six months. There was no case of infection. All patients complained of pain over the iliac bone graft site. One fell down three weeks following surgery and sustained a fractured ilium. In this patient, two bone grafts were taken and the second was a vertical graft. This patient was permitted to stay

at bed rest for ten days and became asymptomatic. There was one death in the series during surgery because of an inadequate airway. Two grafts extruded and both were treated by secondary surgical procedures with removal of the extruded plug, re-drilling of the hole and the insertion of a large plug. Both of these patients did well post-operatively.

Post-Operative Care: All patients were told to drink with a straw and were allowed out of bed as soon as comfortable. The average hospital stay was six days. Two patients were placed in 4 poster braces and 17 in cervical collars.

Results

Patients were grouped as follows:

1) Excellent: No complaints and full range of motion of the cervical spine, 96 patients.

2) Good: Occasional complaints and occasional stiffness of the cervical spine, 43 patients.

3) Fair: Some type of chronic discomfort although minor in nature and persistent minimal limitation of motion, 20 patients.

4) Poor: No change with surgery. 3 patients.

Conclusions

A series of two hundred patients with the cervical syndrome has been treated over a 10 year period with results leading to the following conclusions.

1) Discography is an essential examination to determine pathology in the cervical spine.

2) The small proportion of patients who do not respond to conservative management may be benefited by proper surgery. The mortality and morbidity of the procedures is minute and the technic is easily mastered.

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109 South Munn Avenue

What Has Happened To The Diploma Nursing Schools?

Hospitals which have closed their diploma nursing schools by and large continue to be involved in nursing education, according to a report issued by the National League for Nursing. A survey was made of 221 diploma nursing programs which closed between 1959 and 1968. It found that 63 per cent now offer clinical facilities for practical nursing programs; 49 per cent for associate degree programs (usually in junior and community colleges); 31 per cent for baccalaureate degree programs in senior colleges and universities; and 11 per cent for other diploma programs. In 1959 there were 918 diploma programs graduating 59 per cent of the basic nursing students. By 1968 the number of programs had dropped to 728 with a commensurate decline in graduations to 39 per cent. Thus, hospitals continue to supply the essential ingredient of nursing education (clinical contact with patients) but the control of nursing education is gradually shifting to institutions of higher education.

The report entitled "Present Involvement in Nursing Education of Institutions Whose Diploma Programs Closed," is available from the National League for Nursing, 10 Columbus Circle, New York, 10019 for 75¢ a copy. Ask for Publication #19-1374.

An "aggressive approach," suggest the authors, is justified in the surgical treatment of abdominal aneurysms.

Abdominal Aortic Aneurysms*

Problems in Management

Luiz Nunez, M.D. and Edward M. Miller, M.D./Englewood

The present study is an attempt to evaluate the treatment of abdominal aortic aneurysms at an active, 400 bed, general community hospital. During the seven year period ending in December 1969, 103 patients were admitted with the diagnosis of abdominal aortic aneurysm. Fifty-four were treated conservatively and 49 underwent surgery. The surgery was done by four general surgeons of "attending" rank.

Of the 54 patients who did not undergo corrective surgery, 32 are dead. Twenty-five died of ruptured aneurysm, two of myocardial infarction, two of ruptured associated thoracic aneurysms and three of diseases unrelated to arteriosclerosis. In most of the autopsied cases, the aneurysm was larger than 8 centimeters. In none was it smaller than 6 centimeters. Thirteen of the patients alive at this time were not considered candidates for surgery because of advanced age (more than 75 years). Nine other living patients were treated conservatively because of severe cardiac or renal disease.

Elective Resections

Thirty-three patients underwent elective operation with seven postoperative deaths, a fatality rate of 21 per cent. During 1968-1969, there were 16 elective operations with two deaths, a mortality rate of 14 per cent. Of the patients surviving surgery, fifteen received less than three units of blood during operation. In the group surviving surgery, 60 per cent experienced one or more postoperative complications: peripheral arterial thrombosis or embolism—9; thrombophlebitis—6; paralytic ileus—5; pulmonary embolism—3; urinary infections—3; bloody diarrhea (ischemic colitis)—2; wound disruption—2; adhesive intestinal obstruction—1; and wound infection—1. During the postoperative period, six patients required peripheral embolectomy. The patient with postoperative intestinal obstruction underwent lysis of the offending adhesion with good result.

Of the seven patients who did not survive the postoperative period, causes of death were: myocardial infarction in three; renal failure in two; massive gastric aspiration in one, and hemorrhagic shock in one. Six of these patients had required reoperation; four for embolectomy, one for repair of an anastomotic leak, one for repair of a small rent in the aorta at the site of cross-clamping, and one for mid-thigh amputation. Other complications in this group were: atelectasis, hemiplegia, cardiac insufficiency, paralytic ileus, and intravascular coagulation syndrome with diffuse bleeding (the patient having received 23 units of blood in 12 hours).

It is interesting to note the absence of cardiac complications in the group surviving surgery. In all probability, this reflects their relatively better preoperative cardiovascular status. Average age of the survivors was 65 as compared to 70 in the fatality group. Significantly, 87 per cent of those who died during the hospital period had undergone reoperation compared with 27 per cent of those who survived.

Emergency Resections

Of 16 patients undergoing emergency resec-

* This work is from the Englewood, (New Jersey) Hospital. Dr. Nunez is a resident in surgery there, and Dr. Miller is an attending surgeon.

tion because of acutely ruptured aneurysms, eleven (68 per cent) died in the immediate postoperative period. During 1968-1969, there were 13 emergency resections, with 5 deaths, a mortality of 62 per cent. Five patients presented histories of previous myocardial infarctions. Four had undergone previous surgery for occlusive or aneurysmal disease of the aorta or peripheral arteries. Three died of massive aspiration pneumonitis. Signs of intravascular coagulation were observed in three patients who died of diffuse bleeding following rapid transfusion of 13 to 20 units of blood. Hemorrhagic shock was the cause of death in three. Five patients demonstrated evidence of severe acute renal tubular necrosis. Of the patients surviving surgery, one required postoperative femoral embolectomy. The average number of units of blood received by those surviving surgery was 6 as compared to more than 10 in those who died.

Comment

Five year survival rates of untreated abdominal aortic aneurysms are seldom more than 30 to 35 per cent. Removal of the aneurysm approximately doubles the patient's life expectancy. Most agree that aneurysms (symptomatic or not) in patients younger than 75 years of age should be resected. Some contend that asymptomatic aneurysms less than 6 centimeters in diameter are less likely to rupture, and are apt to yield a more prolonged survival. Our mortality rate for emergency operations for acutely ruptured aneurysms was 68 per cent; and 21 per cent for elective aneurysmectomy, results which are comparable to those published in 1968 covering a similar period.[1] Recently, the mortality rate for elective resections has been reduced to 14 per cent. These figures further emphasize the need for surgical intervention before catastrophic rupture occurs.

Despite the gradually diminishing mortality rate, postoperative complications have been frequent. Peripheral embolectomy was done ten times during the post-resection period; in three cases the patient died. Prophylactic use of the Fogarty catheter before terminating resective surgery should accomplish much toward prevention of this early complication. Atelectasis and aspiration pneumonitis were common, and, in the emergency cases, the latter resulted in three deaths. Ventilatory support and greater attention to gastric decompression, preoperative and postoperative, perhaps with wider use of gastrostomy, should aid in prevention of pulmonary complications. Intravascular coagulation resulting from massive whole blood transfusion precipitates a vicious cycle of consumption coagulopathy followed by diffuse bleeding and further transfusions. This situation occurred most often in the group requiring emergency surgery. Volume replacement with balanced electrolyte solutions rather than with whole blood along with careful administration of bicarbonate to combat metabolic acidosis will reduce the tendency to coagulopathy. Heparin, low molecular weight dextran, and cortisone should be used early to inhibit intravascular coagulation and reduce the incidence of pulmonary micro-emboli. The resources of a well-functioning intensive care unit accomplish much toward the reduction of risk in this type of surgery.

Summary

During the period 1962-1969, 33 patients underwent abdominal aneurysmectomy at the Englewood Hospital with a 21 per cent mortality rate. During the last two years studied, there were 16 elective resections with only two deaths, a mortality rate of 14 per cent. Sixteen patients underwent emergency operation for acutely ruptured aneurysms with a 68 per cent mortality. Of 54 patients with aortic aneurysm who did *not* undergo surgery, 60 per cent died during the period studied, the majority because of ruptured aneurysms. Prevention of postoperative embolism and disturbances of intravascular coagulation as well as prophylaxis against pulmonary insufficiency should help to diminish the present high complication rate. It is our feeling that an aggressive approach to the surgical treatment of abdominal aneurysms is justified.

[1] May, A. G. *et al.*: *Surgery*; 63:711 (July 1968)

240 E. Palisade Ave.

The doctor too often feels helpless when called to the bedside of a patient who has just had an acute stroke. Here is a practical outline of a management approach.

Treatment Of The Acute Stroke*

Marvin E. Jaffe, M.D./
Huntingdon Valley, Pennsylvania

Stroke is a cerebral disease of acute onset due to vascular causes. The specific cause of the acute cerebral lesion may be thrombosis, hemorrhage, or embolism, or even a nonvascular lesion simulating stroke, such as subdural hematoma or tumor.

Our aims in treating acute stroke must be to preserve life and function, to prevent the occurrence of further disability, and to foster the most rapid and complete recovery possible. All of this, while arriving at a specific diagnosis.

We must recognize the significance of disturbances in other organ systems as they may affect cerebral function. Metabolic encephalopathy due to cardiac, pulmonary, renal, hepatic, or endocrine disease usually presents as a diffuse cerebral dysfunction. But, they may also present as focal or generalized seizures, or as a stroke-like syndrome. In the patient with previously subclinical cerebrovascular disease, a metabolic disturbance such as hypoglycemia or uremia may present as a stroke. Severe systemic disease will complicate the management of stroke.

The physician who cares for the stroke patient must remember always that the ultimate return of function to the ischemic brain depends entirely on the comprehensive early management of the whole patient.

The interdependence between borderline cerebral metabolism and cardio-pulmonary function has made attractive the concept of the "Stroke Care Unit" where important parameters may be closely monitored and corrected as needed by a specially trained, highly skilled medical treatment team.

The first need of the patient with depressed level of consciousness is a clear airway. This is most critical in the brain injured patient where the cerebral swelling caused by hemorrhage or infarction is further compounded by cerebral vasodilatation and changes in the blood/brain barrier due to hypercapnia and hypoxia. All this may cause increased intracranial pressure and cerebral edema. If necessary, a cuffed endotracheal tube or tracheostomy should be used to insure a free airway.

The next requirement is that the oxygenated blood, (cleared of excess carbon dioxide) is sent to the brain with an adequate perfusion pressure. During the acute stages of stroke, the cerebral vessels involved are already maximally dilated due to tissue acidosis and ischemia, and further dilatation with either carbon dioxide or pharmacological agents is not only unnecessary, but probably undesirable.

Maintenance of blood pressure and cardiac output is mandatory to sustain cerebral blood flow. Normally, the cerebral vessels are able to maintain cerebral blood flow despite relatively wide variations in arterial pressure. In the presence of acute ischemia or anoxia, the cerebral vessels lose this autoregulatory capacity. Blood flow tends to follow blood pressure as if the vessels were passive tubes. Evidence of myocardial infarction, arrhythmias,

* Read before the Section on Medicine, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 18, 1970. Dr. Jaffe is an instructor in neurology at Jefferson Medical College in Philadelphia.

or failure must also be assiduously sought and corrected if found.

If, as rarely happens, the stroke patient develops *hypotension,* some extracranial cause must be sought and the hypotension rapidly corrected. The more common causes are myocardial infarction, occult hemorrhage, or pulmonary embolism.

On rare occasions, the stroke patient may present with status epilepticus. In addition to the emergency measures outlined, it is important to stop the continuous seizures. Diazepam, 5 to 20 milligrams intravenously, has been found to be an effective treatment. However, the effects of this drug are of short duration. Treatment with more conventional anticonvulsants such as Dilantin® or phenobarbital must be begun simultaneously.

Having established an adequate airway and corrected any circulatory disturbance present, the history and physical examination should be reviewed to arrive at a specific diagnosis. Routine laboratory studies are seldom immediately helpful but should be drawn as an aid in following the patient's future course. If the patient seems dehydrated, or appears unable to tolerate oral intake, an intravenous may be started. Rehydration may reduce blood viscosity and thereby improve cerebral blood flow. Additional glucose may be given if one suspects hypoglycemia. If a catheter is necessary, take care to avoid infection.

Lumbar puncture is done in most patients with stroke. If indicated, it should be accomplished early in the course of illness for the following reasons:

(1) To establish whether intracranial bleeding has occurred. This is especially important if anticoagulant therapy is anticipated.

(2) If signs of meningeal irritation are present, to differentiate between subarachnoid hemorrhage and infection, and

(3) To exclude neurosyphilis.

The spinal tap, like any other clinical test, is not infallible. Blood will not be seen in the cerebrospinal fluid in some 20 per cent of patients with hemorrhage when they are first tapped. If the tap is repeated at a later time, blood or xanthochromia may appear.

A slight increase in white cell count may be seen with infarction, as may mild elevations in protein (less than 100 milligrams per 100 milliliter). Larger increases should bring to mind the presence of a non-vascular lesion such as intracranial tumor or a coexistent medical illness such as diabetes.

The electroencephalogram is usually not helpful in the acute stroke, but serial EEG's may be useful in deciding whether cerebral function is improving or getting worse. Sometimes improvement in the EEG pattern may anticipate clinical improvement by several days.

A brain scan is not useful in the acute emergency situation, but may be helpful in distinguishing between stroke and tumor in the less critical cases. If the scan is positive within the first 48 hours, the lesion is probably *not* a thrombotic stroke. On the other hand, a normal early scan which becomes positive in the first week is compatible with stroke. With the passage of more time, it will become negative again.

In the patient whose signs are rapidly progressing, or who begins to show evidence of brain stem dysfunction, pupillary abnormalities, respiratory changes, decerebrate or decorticate posturing, or in whom papilledema develops, one must immediately consider the possibility of intracranial mass, hematoma (either intracerebral or sub-dural), tumor, or abscess. Under these conditions, arteriography is immediately indicated. Life can be saved by the early recognition and by specific diagnosis and treatment of progressive neurologic decompensation due to a progressing intracranial mass. Subarachnoid hemorrhage is also an indication for early arteriography.

In most stroke patients, angiography is not

necesary. The angiographic dye is itself toxic to blood vessels and seems to affect diseased vessels more than normal ones. This is particularly true in the presence of slowing of the circulation. Should there be any diagnostic doubt, however, an angiogram should be done.

Once the physician has assured that all immediately remediable conditions which might result in rapid deterioration of cerebral function have been corrected, he may then proceed to the next stages of medical management and rehabilitation.

2100 Packard Avenue (19006)

The GP as a Family "Specialist"

Vernon Wilson, M.D., is vice-president of the University of Missouri, formerly dean of its medical school and a family doctor by inclination. In August 1969 he wrote a now widely hailed article on the GP as a "specialist in family practice." He suggests that here is the physician who "will practice medicine on a continuing, comprehensive basis as an advocate rather than on an emergency, episodic basis, who will emphasize preventive medicine as much, or more, than curative medicine. This new doctor will have entire family units as his patient entities, because of the fundamental interaction factors in his comprehensive-care approach. He will see each person as a patient but each patient must be considered against the backdrop of the family unit."

Dr. Wilson writes that the new doctor will be taught according to an approach based on insight into the nature of human relationships, beginning in his undergraduate years and continuing through his family practice residency. He explains that though the quality of concern vital to family practice cannot be taught, "you can teach existing knowledge that will be useful in the hands of the concerned person . . ." He adds that there is "no lack of raw, unchanneled concern in the young" and that "the trick is to channel it effectively to produce results." This, he says, can be done "via formal training in the behavioral sciences and the informal, but more meaningful, vehicle of experience with patients in the family practice unit."

In an important comparison, Dr. Wilson notes that, "the ultimate distinction between the new family physician and members of the existing clinical specialties will be the former's ability to relate the parts to the whole, the special talent to the basic task."

Dr. Wilson believes the new specialist will not be produced in numbers by the educational facilities until the mid-1970's, but that present general practitioners who have kept up with medical advances through continuing study, and who pass the certification examination, will serve as the foundation for the new specialty. He describes the new specialist as having greater geographic flexibility than limited specialists and "without the taut lifelines to medical centers." This flexibility, he adds, will enable the family specialist "to function in the small city or town on much the same basis as the current general practitioner," thereby eventually helping the serious shortage of physicians in sparsely populated areas to take care of itself.

Dr. Wilson recognizes that there are "cautionary voices" which warn that the new specialty will not answer the public's acknowledged need for primary, comprehensive health care. He concludes, however, that others, including leaders in medical education, see "the need to fashion a true specialist in family practice, a new kind of highly competent, comprehensive, primary-care physician, in sufficient numbers to serve the public, as the basic order of medicine's business today."

Here is a case of fixed splitting of the second sound in a young man with the "straight back syndrome."

Fixed Splitting Of The Second Heart Sound

Its Significance In The Straight Back Syndrome

Harry M. Friedland, M.D.
Saul O. Sobol, M.D./Newark

The straight back syndrome[1] has been recognized in recent years as a cause of the "innocent" murmur.[2] The patient to be described in this report had a systolic murmur heard all over the inner precordium with a prominent fixed split of the second heart sound, suggesting initially some form of congenital heart disease.

A 16-year-old boy had no symptoms referable to the cardio-respiratory system. He was a tall, slender boy with a very narrow AP diameter of the chest and a loss of the natural dorsal kyphosis. Pulse was 72 and regular. Blood pressure was 120/80 and respirations 18 per minute. There was a visible and palpable systolic impulse maximal at the third and fourth intercostal space occupying the inner precordium. The first heart sound was split at the base and at the apex. The second heart sound exhibited fixed splitting in the pulmonic area in both the supine and sitting position. There was a grade 2/6 ejection systolic murmur maximum at the pulmonic area without a palpable thrill. Point of maximum impulse was in the fifth intercostal space at the midclavicular line.

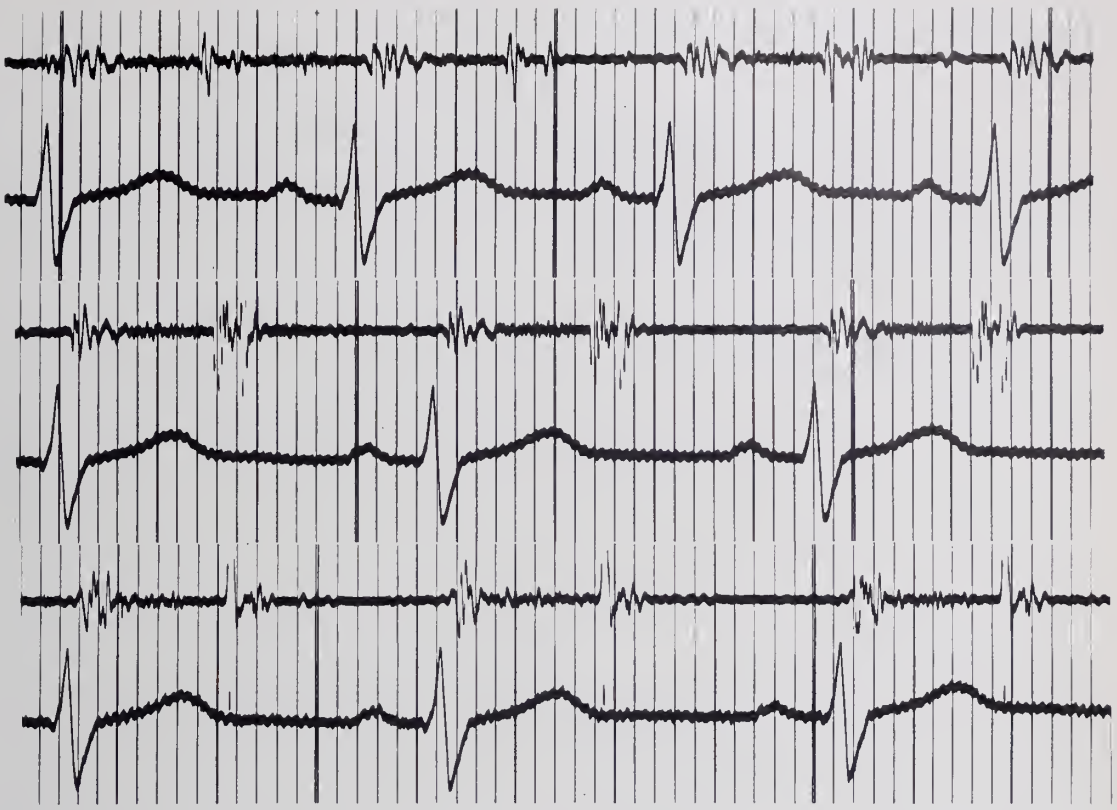
X-rays showed the heart to be vertical in position with a tear-drop appearance in the PA view. The pulmonary arterial segment was slightly elongated. The lateral film (see illustration) demonstrated a straight thoracic spine and a narrow heart. Pulmonary vascularity was within normal limits. The right oblique film showed bulging of the pulmonary arterial segment. The right ventricle was within normal limits, as was the right atrium, in both routine and barium filled esophagus films.

The electrocardiogram showed right axis deviation with a frontal plane QRS axis of + 140°. There was a prominent R wave in V_1 and aVR with a delay in the upstroke of V_1. No other conduction defect was present.

The phonocardiogram (see figure) showed distinct wide splitting of the first heart sound,



Lateral roentgenogram with barium swallow showing the absence of the normal dorsal kyphosis.



Phonocardiogram taken at aortic and pulmonic areas and Erb's point showing fixed splitting of the second heart sound.

measuring 0.06 of a second. This was most prominent at Erb's point. The second heart sound was also split in both the aortic and pulmonary area. On inspiration, the split measured 0.07 seconds, and during expiration closed to 0.05 seconds. At no time did the two sounds fuse. The pulmonary component was larger than the aortic component. There was a group of low amplitude systolic vibrations seen in the pulmonic area of moderate frequency, 160 cycles per second. Similar vibrations were also seen, to a lesser degree, at the aortic area and Erb's point.

The cardiac features observed in this patient are similar to those of other patients with "straight back syndrome" reported in the literature: pulmonic ejection murmur, palpable left para-sternal systolic impulse, loud delayed sounds of tricuspid valve closure, vertical electrical axis, prominent R wave in V_1 or aVR, radiologic prominence of the pulmonary arteries, and a lateral roentgenogram revealing the diagnostic straight dorsal spine without the normal dorsal kyphosis.

The phonocardiogram confirms the clinical impression of splitting of the first sound with fixed splitting of the second sound. Most cases of the "straight back syndrome" reported in the literature describe either physiologic splitting of the second heart sound or a single sound.[3, 4] However, deLeon,[4] *et al.*, found six patients in whom the second heart sound split widely on inspiration and failed to fuse during expiration. The fixed splitting of the second heart sound is similar to that found in atrial septal defect,[5] and other organic diseases.

The prominent R wave in V_1 is related to the extremely vertical heart with anterior orientation of the crista supraventricularis.[6] The physiologic mechanism responsible for the fixed splitting of the second sound in this condition is not known, but is probably re-

lated to the pancaking effect on the heart by a narrow A-P diameter of the chest with restriction of expansion of the heart.

Since many patients with the straight back syndrome are initially thought to have organic heart disease, it is important to be aware that this may present with the usually ominous fixed splitting of the second heart sound.

We wish to thank John H. Donnelly, M.D. for performing the phonocardiogram and assisting in preparation of the paper.

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413 Mt. Prospect Avenue

The Post-Menopausal Woman

A medical film that offers considerable potential for an informative and provocative program on estrogen replacement therapy is *The Long-Range Problems of the Postmenopausal Woman.* This film is now available for showing to medical groups. Running time is 43 minutes; color and sound. It was filmed across the nation, with Dr. Allan C. Barnes of Johns Hopkins Hospital presiding in Baltimore; and with Dr. Herman I. Kantor, Clinical Professor of Gynecology and Obstetrics, the University of Texas in Dallas; and Dr. Gilbert S. Gordon, Professor of Medicine, University of California Medical Center in San Francisco, joining him in animated discussion.

After a vivid introduction by Dr. Barnes on estrogen deficiency as a serious disease requiring medical treatment, the subject is pursued with Dr. Kantor on the emotional aspects of the problem, and on the diagnosis and treatment of osteoporosis with Dr. Gordon.

To obtain this film for an early showing at one of your group's continuing educational projects, write to: John B. Jewell, M.D., Medical Department, Ayerst Laboratories, 685 Third Avenue, New York, New York 10017

New First Aid Guide

An easy-to-read guide to *First Aid in the Home* has been produced by the Council on Family Health. This guide has self-adhesive backing so it can be fastened easily to the inside of the medicine chest or other handy surface in the home.

The Council on Family Health, a non-profit organization sponsored by members of the drug industry, prepared the guide in cooperation with the American Medical Association. This book provides information on what to do in the event of poisoning, bleeding, burns and scalds, shock, broken bones, and eye contamination. It has illustrated instructions on the mouth-to-mouth breathing technic of artificial respiration.

At the top of the sheet is space for emergency telephone numbers for the doctor, hospital, dentist, pharmacist, police and fire departments, ambulance or rescue squad, and poison control center.

Single copies of the sheet may be obtained by sending 15 cents to cover costs of handling and mailing to the Council on Family Health, Department FA, 485 Madison Avenue, New York 10022. Quantities may be ordered at much reduced rates.

Special Article

Medicine and Public Health in New Jersey

The following was prepared and read by Fred B. Rogers, M.D., of Trenton, at a public hearing before the New Jersey Historical Commission, State House, Trenton, May 5, 1970.

Aware of the remarkable heritage of medicine and public health in the Garden State, we owe recognition of accomplishment in these fields during the coming 1976 Bicentennial Celebration of our nation. As one prelude, a day-long symposium on New Jersey's medical history will be held on October 24, 1970, at the State Cultural Center in Trenton. (See announcement, page 566, this issue). Subsequent commemorative events and publications can be arranged through interested individuals, historical groups, and organizations of the health professions.

New Jersey has mirrored the practice of medicine and medical organization in this country since the colonial period. Its physicians have been an able and versatile lot, and The Medical Society of New Jersey, founded in 1766—ten years before the Declaration of Independence—is the oldest medical organization in continuous existence in all of North America. Numerous "firsts" in health matters and medical legislation have come to pass in New Jersey during the past two centuries. These events have been chronicled in two recent books, *Medicine and Health in New Jersey,* by Professor David L. Cowen (1964); and *The Healing Art: A History of The Medical Society of New Jersey,* by Mrs. Arlene R. Sayre and myself (1966).

Professional education, though slow in reaching maturity, is now evidenced by two medical schools, two dental schools, a pharmacy school, several research institutes and pharmaceutical laboratories, and numerous centers for the training of nurses, medical technologists, and allied workers. In addition, programs for the continuing education of practicing physicians and surgeons, linked to medical schools, and internship and residency training, based in various hospitals, afford modern facilities for providing a broad range of health services.

The Medical Society of New Jersey was founded on July 23, 1766 at New Brunswick. On that day, seventeen physicians signed its "Instruments of Association and Constitutions," and elected as president the Rev. Robert McKean, a medical missionary who was rector of St. Peter's Episcopal Church in Perth Amboy. The site of the Society's founding is now marked by a roadside tablet, erected by the state in 1966 near the Raritan River bridge in New Brunswick.

Professional progress stemmed from the earliest years of The Medical Society of New Jersey. A fair-fee schedule was issued and in 1772 an appeal was made to the legislature to license physicians in the state. Members of the Society played a conspicuous role in the War of Independence. Drs. William Burnet, of Newark, its second president, and John Cochran, of New Brunswick, third president, became the Surgeons-General, respectively, of the Eastern and Middle Departments of George Washington's Army. Dr. Nathaniel Scudder, of Freehold, 4th President was killed in action.

By 1816, growth of the state body led to its subdivision into component county medical societies. The first of five "district" societies formed then was that of Somerset County. Today, there are twenty-one county medical societies in the parent organization, with almost 8,000 members.

Early interests in public health within the Society led to physicians' recording of vital statistics—births and deaths—beginning in 1820. In 1847, this effort resulted in a state law requiring the keeping of such statistics, and, by 1877, the establishment of the New Jersey State Health Department.

In 1819, members of the Medical Society were instrumental in compiling the first edition of the *U.S. Pharmacopoeia.* Three years later Society members warned in print against adulterated drugs, and in 1870 aided the founding of the New Jersey Pharmaceutical Association—like the Medical Society, the oldest of its kind in the United States.

As a result of a ten-year campaign led by the Medical Society, the nation's first state psychiatric hospital was established at Trenton in 1848. That same year, the state got its first medical journal, the *New Jersey Medical Reporter.* This was later succeeded by the Society's monthly *Journal.* At least two members of the Society, Drs. Thomas Dunn English (1819 to 1902), of Newark, and William Carlos Williams (1883 to 1963), of Rutherford, have achieved national distinction as men of letters.

As early as 1851, Society recommendations helped achieve protective labor laws for children in New Jersey, and nine years later other legislation was passed to aid industrial workers and improve their working conditions. Two Governors of New Jersey, Drs. George F. Fort (1850-53) and William Augustus Newell (1857-60), have been physicians.

The first charcoal, sand, and gravel filter used to clean a municipal water supply in New Jersey was set up at Elizabeth in 1855. Laws to protect water sources followed, and the first chlorination of a public water supply (at the Boonton Reservoir of the Jersey City Water Works), in 1908, was a pioneer effort in this country. Fluoridation of water was instituted about fifty years later to reduce markedly the number of decayed, missing, and filled teeth in our population.

With the leadership of Dr. Henry L. Coit of Newark, with medical society backing, a fight for pure milk was launched in Essex County in 1890. This victory provided a model for other states and many foreign countries. Mosquito control measures, advocated in 1904 and widely implemented by 1926, led to drainage and restoration of millions of dollars of tax-ratable land. Air pollution control efforts have more recently been effected in highly-industrialized areas of the state.

Maternal and child health activities in New Jersey, in 1918 representing the largest such allocation up to that time by any state, led to significant reductions in preventable illness and death. Visiting Homemaker Service, instigated by the Woman's Auxiliary of The Medical Society of New Jersey in 1951, was the first such statewide service in the nation chartered by legislative consent. And in 1960, national accreditation of nursing homes for the aged found those in New Jersey having among the highest standards in the United States.

Earlier, in 1932, by participation with members of the New Jersey Hospital Association, The Medical Society of New Jersey helped launch a plan for non-profit prepayment hospital insurance, now generally known as Blue Cross. The Society itself later began a non-profit scheme for prepaid insurance of medical-surgical fees similar to that now called Blue Shield. Subsequent nationwide growth of these programs was fostered by New Jersey's example.

The New Jersey College of Medicine and Dentistry, opened in 1956, and the Rutgers Medical School, initiated in 1965, brought to fruition the hopes of many people for formal medical education in the state. The Fairleigh Dickinson University School of Dentistry and the Rutgers University School of Pharmacy had earlier achieved similar goals in their respective fields.

New Jersey physicians have played an important role in the activities of national organizations such as the American Medical Association, formed at Philadelphia, Pennsylvania, in 1847, and the American Public Health Association, founded at Long Branch, New Jersey, in 1872. (The A.P.H.A. will hold its centennial meeting at Atlantic City in 1972.)

Two New Jerseymen, Selman A. Waksman and Dickinson W. Richards, are included among the internationally-known Nobel laureates in physiology and medicine. Dr. Waksman was cited in 1952 for discovery of the antibiotic streptomycin, and Dr. Richards in 1956 for his research on the dynamics of the cardiovascular system. Each was honored by the state medical society during its bicentennial celebration.

The founders of The Medical Society of New Jersey, over two centuries ago, aimed well when they stated its purposes to be "for mutual improvement, the advancement of the profession, and the public good."

Alcoholism Legislation and the A.M.A.

The American Medical Association supports, in general, legislation (S.3835) that would provide a comprehensive federal program for the prevention and treatment of alcohol abuse and alcoholism. Dr. Marvin A. Block, a member of the AMA's Committee on Alcoholism and Drug Dependence, termed the measure "a major landmark in public policy" in the field.

The bill would establish a National Institute for the Prevention and Control of Alcohol Abuse. The Health, Education, and Welfare Secretary would be required to submit within one year a detailed federal program, develop model programs for states, and conduct research and educational activities. Federal grants would be authorized for prevention, treatment, and rehabilitation facilities and programs at the state and local level.

Dr. Block specifically favored several of the bill's provisions, including one that provides that treatment and control programs should be community based: "insofar as it is feasible and economically sound, most alcoholics should be treated in their own communities and not be relegated to a distant centralized institution for treatment," he said.

But the AMA spokesman questioned some other provisions. He saw no need for a new institute. He suggested the present National Center for Prevention and Control of Alcoholism could perform the proposed institute's duties and responsibilities.

The AMA also questions whether alcoholics should be made eligible for welfare cash benefits and for health care under other government programs, such as Medicare and Medicaid, on the ground that they are alcoholics.

Noting that the legislation is concerned mainly with operation of programs by public and voluntary agencies, Dr. Block added that: "We should not overlook, however, the role that the private physician has played, and can play, in this important area. More and more, the physicians of this country are facing up to the problem of alcoholism in their daily practice. They are recognizing that, as difficult as alcoholism may be, it is an illness which can be dealt with, in cooperation with other professionals in the community."

The bill was introduced by Senator Harold E. Hughes, himself a recovered alcoholic and chairman of the subcommittee.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

July 19, 1970

A regular meeting of the Board of Trustees was held on July 19 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

United States 200th Anniversary . . . Authorized the Historian-Archivist (Morris H. Saffron, M.D., Passaic), with the assistance of Dr. Fred Rogers, Trenton; Dr. Peter Guthorn, Neptune City; and Dr. David Brewer, Jr., Woodbury, to investigate the possibility of MSNJ's participation in the Medical Sciences Division of the Smithsonian Institute's commemoration of the 200th anniversary of the United States and the City of Philadelphia Bicentennial plans which include the development of a permanent historical exhibit of medical events from New Jersey, and report their finding to the Board within three months.

. . . Directed that if it is not possible to participate in both celebrations preference be given to the one in Philadelphia.

Physicians' Welfare Fund . . . Approved President Satulsky's appointment of the following as members of a committee to define the terms of administration of a physicians' welfare fund, to be financed by an annual dollar per capita taken from surplus (See page 499, August 1970 issue):

Richard Chamberlain, M.D. (1st District)
John J. Bedrick, M.D. (2nd District)
Joseph J. Kline, M.D. (3rd District) Chairman
Frederick W. Durham, M.D. (4th District)
A. Guy Campo, M.D. (5th District)

Exhibit on "Dyslexia" . . . Concurred in the Executive Committee's action authorizing the Committee on Conservation of Vision, Hearing, and Speech to present an exhibit on "Dyslexia" at the New Jersey Education Association convention in Atlantic City, November 5 to 7, 1970 (expenditures not to exceed $200).

Report of Legal Counsel . . . Approved the report of Legal Counsel which stated that the materials submitted by PRO Services Inc. concerning the Society's Keogh Plan for Physicians were in order, that the power of attorney requested to be given to Thomas J. Timoney, Esquire, is proper, and that there will be no charge to the Society in the event said attorney is obligated to represent MSNJ's interests.

Council on Legislation . . . Approved as amended the report of the June 11th meeting of the Council on Legislation, including the recommendations:

1. *A-309 and A-706*:

Since these bills are technically the same (to provide that where injury or death is caused by the negligence of a physician, surgeon, nurse, dentist, chiropractor, osteopath, or other person rendering service under the Workmen's Compensation Law, such person shall be liable at common law for any negligence), Council recommended a position of "approved" instead of "no action" on A-309 and "approved" on A-706, as previously recommended.

2. *Official Position of MSNJ on Bills of Medical Import:*

S-747 —To establish proceedings for the protection of children under 16 years of age who have had serious physical or mental injury inflicted upon them by other than accidental means. *APPROVED*

S-752 —Provides that blood, blood plasma or tissue or organs shall not be considered commodities subject to sale or barter. *ACTIVE SUPPORT*

S-757 —To provide that it shall be unlawful for any person, firm, or corporation to advertise or solicit eye examination or visual services or advertise for sale eyeglasses, lenses, frames, mountings, prisms or other optical appliances by newspaper, billboard, radio, television, window display or other means or to use any method of persuading the public to buy visual correction services. *DISAPPROVED*, on the grounds that the end result would be economically against the public interest and discriminatory against manufacturers and suppliers of lenses and prisms who would provide these articles at lower costs.

S-786 —To provide that it shall be unlawful for ophthalmic dispensers or technicians to advertise or employ displays in such a way as to suggest they are qualified to give professional advice concerning eye care. *APPROVED*

S-810 —To provide that it shall be a high misdemeanor for any person to add any narcotic, stimulant, depressant or hallucinogenic drug or substance to any food, beverage or other comestible, and punishable by imprisonment for not less than 10 years or a fine of not more than $5,000 or both. *APPROVED*

S-817 —To authorize the Department of Environmental Protection to establish pre-treatment standards for sewage that may be discharged into public sewage treatment plants. *APPROVED*

S-821 —To provide that physicians, pharmacists, nurses, veterinarians and similar persons shall be exempt from provisions of the act concerning unlawful sale or possession of prescription drugs when they are acting in regular course of their business or profession. *APPROVED*

S-838 —To provide any employee, holding the degree of M.D., regularly employed by a duly licensed hospital may, upon application to the State Board of Medical Examiners, be granted an exemption from provisions of the act concerning medicine and surgery provided such employee is limited to performance of emergency medical service under the direct supervision of a duly licensed physician. *DISAPPROVED* because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.

S-851 —To provide for the New Jersey Controlled Dangerous Substances Act to be administered by the Commissioner of Health. (Substantially the same as A-967 of this year.) *ACTION DEFERRED*, because a copy of the bill was not available for the Council's review. It therefore suggested that emergency action be taken on this bill when a copy becomes available.

S-872 —To provide that the definition of "pharmacy" and "drugstore" shall include every place in which drugs, prescriptions and poisons are possessed for compounding and dispensing at retail; to provide that such definition shall not include the dispensing of drugs in a hospital, nursing home, convalescent center, industrial dispensary, medical clinic or similar institution where such are dispensed under an institutional permit to inpatients, employees, and outpatients. *NO ACTION*

S-875 —To provide comprehensive revisions to the Act for the uniform control and licensing of dogs and kennels to aid in preventing the spread of rabies. *APPROVED*

S-884 —To authorize the establishment and maintenance of a confidential registry of narcotic addicts and drug abusers and provides immunity against suit to any person providing information on the use or users of drugs. *APPROVED*

As of the date of this meeting, S-884 was not introduced in the Legislature. However, the Legislative Analyst read the bill from a copy he had received from the Governor's office. It was the understanding of the Legislative Analyst that this bill would be introduced at the next meeting of the Legislature—June 22, 1970. For this reason, the position of "approved" was taken subject to the concurrence of the emergency committee for the Council on Legislation. (S-884 was subsequently introduced in the Senate.)

A-915 —To authorize the Director of Health to establish a program for immunization of citizens against rubella disease. *APPROVED*

A-921 —To provide for rubella innoculation for school children. *APPROVED*

A-922 —To prohibit erection of billboards, neon signs or commercial advertising within 300 feet of a traffic sign, signal or intersection along any State or county highway. *APPROVED*

A-929 —To permit noncitizens to be registered as physical therapists. *DISAPPROVED* because, for foreign physicians, the declaration of intent to become a citizen is a method open to such individuals to qualify for registration and, therefore, this legislation is not necessary.

A-937 —To permit courts, upon application after a lapse of five years after conviction, to expunge the record of first offenders 25 years of age or younger, who have been convicted of possession of marijuana. *APPROVED*

A-941 —To require the licensing, inspection, and regulation of medical care facilities; to provide for issuance of certificates of need by the Commissioner of Institutions and Agencies for construction and expansion of medical facilities; to provide for enforcement by the Department of Institutions and Agencies. (Substitute for A-200 of 1970.) *NO ACTION*

A-946 —To authorize the confinement of insane persons and those acquitted of crime because of insanity to a New Jersey state hospital to be designated by the Commissioner of Institutions and Agencies. *APPROVED*

A-957 —To direct the Board of Education to require immunization of all pupils against rubella as a condition for entrance to kindergarten and grades one through four. *DISAPPROVED*, because it should be up to the individual Board of Education whether immunization against rubella is to be obligatory.

A-960 —To provide that the selling of alcoholic beverages to minors shall be a disorderly persons offense in place of a misdemeanor. *APPROVED*

A-967 —To regulate and control the manufacture, handling, sale and distribution of dangerous substances under the administration of the Department of Health. (Substantially the same as S-851 of this year.) *ACTION DEFERRED*, in view of the position taken on S-851.

A-980 —To create a Population Environment Council consisting of the Commissioners of Environmental Protection, Labor and Industry, Education, Health and Community Affairs and seven citizens to conduct or cause to be conducted studies of the range of problems associated with population growth and related demographic changes. *NO ACTION*

A-988 —To establish the "Open Space Preservation Law" and to create a New Jersey Open Space Council in the Department of Environmental Protection. *APPROVED*

A-989 —To provide that the Department of Environmental Protection shall have authority to adopt and promulgate rules and regulations concerning the pollution of the air, earth and water of the State. *APPROVED*

A-993 —To define "physical therapy" or physiotherapy, to provide for approval of the required course of study by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; to require applicants for registration to pass an examination provided by the American Public Health Association or the Physical Therapy Examining Board which is created in the Division of Professional Boards and other amendments. *ACTION DEFERRED*, until the Council is informed as to how the State Board of Medical Examiners feels about this measure as well as the New Jersey Chapter of the American Physical Therapy Association and the Society of Physiatrists.

A-994 —To permit the Governor to issue a proclamation for apprehending any person, not a narcotic addict and over age 21 on charges—on oath by one or more credible witnesses—of having sold, given, administered or dispensed any hard drugs, or any person aiding such person, and to permit a reward not exceeding $500 for any one person. *NO ACTION*

A-1020 —To provide for the control and regulation of use and application of pesticides, to require registration and to establish "The Pesticide Act." *APPROVED*

A-1034 —To provide for labeling of horsemeat by persons who transport, other than a common carrier, sell or offer such for sale to be effective when the Governor suspends operation of the New Jersey Meat and Poultry Inspection Act. (Companion measure to A-1035) *APPROVED*

A-1035 —To permit the Governor to suspend operations of the "New Jersey Meat and Poultry Inspection Act" upon notification that the United States Department of Agriculture intends to extend provisions of the Federal Meat Inspection Act to operations and transactions wholly within this State. (Companion measure to A-1034) *APPROVED*

A-1037 —To permit boards of education to apply to the Commissioner of Education for approval of programs of education for adults in regard to the use of narcotics. *APPROVED*

A-1054 —To appropriate $50,000 to the Department of Education for supervision of teacher training and instructional programs in connection with drug education programs for 610,000 students in secondary school districts. *APPROVED*

A-1056 —To authorize the Commissioner of Education to establish summer workshop and training programs to train selected teachers to teach a drug education program to secondary school teachers; to provide that the programs shall be under the direction of persons designated by the Commissioner—including representatives of the Departments of Education, Higher Education, Rutgers University, New Jersey College of Medicine and Dentistry, and the Urban Schools Development Council. (Signed into law on 3 June 1970) *APPROVED*

A-1060 —To appropriate $315,000 to the Department of Education for grants to secondary school districts in operation of drug education programs to be allocated on the basis of enrollment as of September 30, 1970 according to a formula as determined by the Commissioner. *APPROVED*

A-1061 —To appropriate $175,000 to the Department of Education to establish summer workshops and training programs to train selected teachers to teach a drug education program to secondary school teachers. (Signed into law on 3 June 1970) *APPROVED*

A-1062 —To appropriate $500,000 to the Department of Health for the purpose of matching Federal funds for the continuation and expansion of the New Jersey Regional Drug Abuse Agency. (Signed into law on 3 June 1970) *APPROVED*

A-1063 —To appropriate $130,000 to the Department of Health for the purpose of broadening the experimental methadone maintenance treatment programs operated by the New Jersey Neuro-Psychiatric Institute at Skillman. *APPROVED*

A-1064 —To appropriate $40,000 to the Department of Institutions and Agencies for the purpose of employing selected teachers in summer programs in connection with the clinical aspects of drug addiction and rehabilitation in the State's institutions and agencies. *APPROVED*

A-1082 —To permit discharges of sewage and other wastes into the Delaware River only if they conform to regulations of the Department of Health and will not kill or injure fish, birds or mammals, to take effect upon similar enactment by the Commonwealth of Pennsylvania. (Companion measure to A-1083) *APPROVED*

A-1083 —To permit discharges of sewage and other wastes into the tidal waters of the State only if they conform to regulations of the Department of Health and will not kill or injure fish, birds or mammals. (Companion measure to A-1082) *APPROVED*

A-1097 —To grant doctors, teachers and other personnel immunity from civil suit for damages for good faith actions in relation to persons addicted to or illegally using narcotic drugs. *APPROVED*

A-1099 —To provide that the Commissioner of Health may waive the requirement of an examination and a public health degree for a health officer's license where a person holds an M.D. or D.D.S. degree, has been licensed by the State, has experience for 15 years, and completed residency requirements. *DISAPPROVED*, in adherence to the policy position taken by the House of Delegates of MSNJ in 1961 and because such legislation would be a retrogressive step in public health in New Jersey.

A-1104 —To define "unnecessary radiation" in the Radiation Protection Act; to add one more member to the Commission, to permit placing an "embargo" on machines considered a radiation hazard. *APPROVED*

A-1119 —To limit the practice of ophthalmic dispensing to licensed opthalmic dispensers. *DISAPPROVED*, because it would be an unnecessary restriction on the practice of optometry and the practice of medicine by duly licensed persons without a concomitant benefit to the public.

A-1128 —To prescribe standards and requirements for emergency stopping systems for motor vehicles using air brakes. *ACTION DEFERRED*, pending a report from the Committee on Traffic Safety of The Medical Society of New Jersey.

A-1133 —To authorize school districts to conduct a non-binding referendum approving or disapproving proposed sex education programs in any public school before any such program may be implemented. *NO ACTION*

3. *Bills to be Noted and Filed:*

S-765 —To provide that the Commissioner of Conservation and Economic Development shall render his approval of action of the Water Policy and Supply Council within 20 days after written receipt of official action taken by such council.

SJR-23 —To create a commission to study the merits of fluoridation of public potable water supplies and health measures and to determine the advisability of making fluoridation mandatory throughout the State.

A-910 —To provide that State statutes and codes on processing, packaging, storage and sale of food for human and animal consumption shall supersede provisions of county or municipal laws.

A-945 —To provide for the "New Jersey State Personal Income Tax Law" establishing rates from 2% to 14% based on the income of residents and non-residents. (Companion measure to ACR-77)

A-1123 —To appropriate $25,000,000 from the Public Buildings Construction Fund for the construction of two narcotics rehabilitation centers in New Jersey.

ACR-77—To amend the New Jersey Constitution, after referendum, to permit the Legislature to incorporate by reference the Federal income tax law in any State tax law on income.

4. *Drug Abuse Registry:*

Council recommended that Resolution #30 (Drug Abuse Registry) be noted and filed since S-884 which would accomplish the intent of this resolution is scheduled to be introduced at the next meeting of the Legislature. (Note: S-884 was introduced June 22, 1970)

5. *Physicians' Exclusive Right to Render Medical Judgments:*

Council recommended that it be suggested to the Chairman of the Council on Medical Services that Resolution #33 be referred for implementation to the Medicare Law Committee of MSNJ.

Chiropractic . . . Approved the following suggestions from the *Ad Hoc* Committee on Chiropractic:

1. That County societies screen telephone directories to validate professional listings and report to MSNJ.

2. That a copy of *At Your Own Risk* be sent to newspaper editors throughout the State.

3. That the Commissioner of Health *and the Commissioner of Environmental Protection* (italics represent Board amendment) be urged to encourage promulgation of regulations to limit x-ray use.

Annual Meeting Committee . . . Approved as amended the report of the July 12th meeting of the Annual Meeting Committee, including the following:

1. *MSNJ Convention Format* (Resolution #15)—Many of the proposals are incompatible with the necessary schedule for conduct of the Society's business; others can be considered if and when Constitution and Bylaws revisions are made that will (through adjustment of the time of the meeting of the Nominating Committee) make possible such changes.

2. *Reference Committees*—Until such time as changes are made in the Constitution and Bylaws as will permit an earlier meeting of the Nominating Committee, the scheduling of Reference Committee meetings on Sunday morning will have to stand. It was agreed that the assignment of items to reference committees be weighed to effect a more even distribution of the workload.

3. *Student Participation*—Suggested that MSNJ continue its practice of inviting the medical schools to send representatives to our annual meetings.

4. *Time Limit on House Debate*—Recommended that the Speaker, with the consent of the House, be instructed to announce to the House of Delegates that no one may speak more than once on any given subject except by express permission of the House, and that the time be limited to four minutes per speaker, subject to the same exception.

5. *Vice-Speaker*—Recommended that the President be empowered to appoint a Vice-Speaker to assist at the sessions of the House of Delegates. The Board directed that the Committee on Revision of Constitution and Bylaws be requested to introduce a constitutional amendment to the 1971 House to make possible the carrying out of this recommendation.

6. *Parliamentary Interpretations*—Recommended that, if a Vice-Speaker is appointed, he and the Speaker familiarize themselves both with Sturgis' Standard Code of Parliamentary Procedure and MSNJ's Constitution and Bylaws, and that together they be responsible for parliamentary interpretations.

7. *Wording of Approval or Rejection of Resolutions*—Suggested that the established procedure of calling upon the House to act upon each individual portion of the reference committee report be adhered to and that the House be urged to "adopt" that portion of the report.

8. *Deadline for Submission of Resolutions*—Recommended that the following statement be included in the memorandum on this subject sent to the component societies each January:

"It may be found necessary to introduce emergency resolutions after the deadline date for the reception of resolutions. An emergency resolution may be defined as one that deals with a matter that could not have been known or anticipated in time to submit the resolution as a regular resolution. A written copy of each such emergency resolution should be filed with the Convention Office in Haddon Hall by 11:00 a.m. on Saturday, 15 May 1971. Emergency resolutions will be identified as such when submitted to the House, and the House will be asked to pass upon them as conforming to the requirement set down for emergency resolutions before they are accepted for introduction and processing."

9. *Woman's Auxiliary*—Recommended the following:

1. That the Woman's Auxiliary be requested to schedule the opening of their registration to coincide with that of MSNJ—10:00 a.m., Saturday, 15 May 1971.

2. That the Woman's Auxiliary registration area be located in the Exhibit Hall adjacent to MSNJ's registration, rather than in the Hotel Lobby.

3. That the Woman's Auxiliary Art Exhibit be located in the Exhibit Hall adjacent to the Auxiliary registration area. It is pointed out that, inasmuch as MSNJ hires security guards for the Exhibit Hall, the Art Exhibit would be better protected in the Exhibit Hall than it can be in the Hotel Lobby.

4. That the Woman's Auxiliary plan more activities for their members on Tuesday in an effort to hold them in Atlantic City until the close of the final session of the House of Delegates on that day.

(The Board directed that the foregoing recommendations be referred to the Woman's Auxiliary for reaction.)

10. *Scientific Programs*—Recommended that New Jersey specialty societies be invited to participate jointly in the 1971 program preparations and to attend the meeting of the Scientific Section Officers in September. It was further recommended that the Section on Metabolism be disbanded and be absorbed by the Section on Medicine.

11. *1974 Annual Meeting*—Recommended that Haddon Hall be informed that the dates of May 18 to 21 have been agreed upon for the 1974 meeting.

12. *Informational Exhibits*—The Board directed that informational exhibits be discontinued unless the exhibitors wish to defray the cost of the exhibit.

13. *Delegates' Copy of Reports and Resolutions*—Directed that with the 1971 meeting Delegates be urged to bring to Atlantic City all materials mailed to them in advance, that duplicate sets will not be available, and that the Delegates be advised of this new procedure at the time of the mailing.

Medical Defense and Insurance . . . Approved the report of the June 14th meeting of the Committee on Medical Defense and Insurance, including the following recommendations:

1. That Mr. Joseph A. Britton be requested to select the most significant and frequent incidents underlying alleged malpractice claims and suits, to be drafted in narrative form for future distribution to the membership. Furthermore, the draft will be forwarded to the defense attorneys for the insurance carrier for review and editing.

2. That the Board of Trustees permit the members of the Committee on Medical Defense and Insurance to attend a joint meeting with the representatives of the Employers Insurance Company, the Joseph A. Britton Agency, and the trial attorneys, for the purposes outlined.

3. That the Board of Trustees suggest that component medical societies stipulate that during the first year of associate membership, as an additional requisite of their orientation program, associate members be required to attend one meeting—regular or special—of their component medical society devoted to the malpractice situation, with all other members invited to attend.

4. That if a D.O. is in partnership with a member of MSNJ, he is not entitled to be insured under The Medical Society of New Jersey's program, since that coverage, by agreement entered with the carrier, is available only to members of the Society. However, if a D.O. is employed by a member of MSNJ, he may be covered under the policy as an employee.

5. That the Board of Trustees approve the reclassification of pathology and allergy from Class 1 to Class 6, in the event the Carrier, Employers Insurance of Wausau, is willing to make such a reclassification.

6. That the Board of Trustees approve the following "Official Procedures" as drafted by the Committee.

OFFICIAL PROCEDURES FOR REVIEW OF CLAIMS OR SUITS INVOLVING PHYSICIANS INSURED UNDER THE MEDICAL SOCIETY OF NEW JERSEY'S ENDORSED PROFESSIONAL INSURANCE PROGRAMS

1. The only agency authorized by this Committee to review cases is the county medical review and advisory committee, which will meet at the call of the attorney of the Insurance Company, under a program coordinated by Mr. Britton, who is MSNJ's Official Broker for professional liability coverage.

2. The attorney or representative of the involved insurance carrier shall contact the chairman of the medical review and advisory committee of the appropriate county. That chairman will assign a physician to review each case for presentation to the full committee, and shall so inform Mr. Britton.

3. The attorney or representative shall arrange to have all necessary information sent to that designated physician, with a transmittal letter accompanying the file containing a brief summary of the facts, allegations, and legal status, together with an indication of when this case should be ready.

4. When a sufficient number of cases are ready, Mr. Britton will arrange for a mutually convenient meeting, preferably on a previously assigned meeting date. His office will advise all parties of the agreed-upon date. An agenda will be sent to the Committee chairman with copies of the review summaries.

5. The Insurance Carrier shall complete the investigation as soon as possible, securing copies of all pertinent records.

6. All procedures shall be conducted according to the rules and regulations set forth by the Loss Control Program approved by the Board of Trustees in October 1968.

7. Attorneys other than the Employers' attorneys representing the defendant (s) will be permitted to attend only that portion of the meeting dealing with their case.

7. That the Board of Trustees request American Mutual Insurance Company to submit a complete list of the defense attorneys used by their company in malpractice cases where the insured is a member of The Medical Society of New Jersey and his policy was written under The Medical Society of New Jersey's program.

Committee on Publication . . . Approved the following recommendations of the Committee on Publication:

1. That the Board of Trustees approve the approximate 7.3 per cent increase in the price scale for the production of *The Journal,* effective with April 1970 issue, and that two copies of the price addendum be signed and returned to Hughes Corporation. (This increase is in accordance with the provision of the contract with Hughes Corporation providing for annual price adjustments.)

2. That the Board of Trustees approve an increase in display advertising rates, effective January 1, 1971, or upon expiration of current contracts, in the amount (approximate) of 15 per cent for one page insertions and 10 per cent for half page insertions. (The new rates are consistent with those of other member journals of SMJAB. The comparative standard of cost per thousand circulation of the twelve times, full page, black and white rate, indicates that *The Journal's* cost per thousand will be fourth of the eight journals with circulations over 5,000, with six journals having lower cost per thousand and twenty-seven higher costs per thousand.)

Woman's Auxiliary . . . Approved on recommendation of the Advisory Committee to the Woman's Auxiliary, the Auxiliary program for 1970-1971, which is substantially the same as that of 1969-1970 with the addition of one item under "Health Careers" — "that the Auxiliary support and cooperate with other community organizations in the promotion of health careers."

Report of AMA Delegates . . . Received as amended (see below--"Concerning Annual Dues") the following report of the New Jersey Delegation to the 1970 AMA Convention:

The 119th Annual Convention of the American Medical Association was held in Chicago from Sunday, 21 June through Thursday, 25 June. The total registration was 20,911. In New York City in July 1969, the total registration was 45,625.

The Medical Society of New Jersey was represented in the House of Delegates by six of its seven elected delegates: Dr. Joseph P. Donnelly, Delegation Chairman; Dr. Frank J. Hughes, Dr. John F. Kustrup, Dr. Jesse McCall, Dr. Luke A. Mulligan, and Dr. Isaac N. Patterson. Dr. Jerome G. Kaufman served as acting-delegate, filling the place of Dr. Marcus H. Greifinger, who was absent because of illness.

All alternate delegates were in attendance: Dr. Louis F. Albright, Dr. John J. Bedrick, Dr. Matthew E. Boylan, Dr. Joseph R. Jehl, and Dr. Robert E. Verdon. Also present as official representatives of MSNJ and in attendance at the sessions of the House of Delegates and its reference committees were Dr. Emanuel M. Satulsky, President; Dr. E. Vernon Davis, President-Elect; and Richard I. Nevin, Executive Director. Dr. Hughes was a member of Reference Committee "D," and Dr. McCall served on Reference Committee "I."

The delegation held its first caucas at 12:30 p.m. on Sunday, 21 June. It met again Sunday evening, and thereafter met in luncheon and late afternoon sessions for the entirety of the convention. We conducted a hospitality parlor with daily open hours from 4:00 p.m. to 7:00 p.m. By special arrangement we welcomed to our parlor and interviewed in some depth all the candidates for the presidential and vice-presidential offices and for the openings on the Board of Trustees and the several councils.

Following established precedent, each member of the delegation was assigned in advance, a specific section of the *AMA Delegates' Handbook* to study and evaluate for report at the first caucus. By this means we were able to appreciate the full content of the advance materials supplied, without imposing excessive burdens on the members individually. We were grateful to have the annotated copies of the "Report on Planning and Development" which had been so well worked out by MSNJ's special committee which studied the Report. Our task was made easier by their efficient work.

At our second caucus (on Sunday evening) we agreed upon positions concerning the items before the House. We also agreed on the assignment of the following delegates, alternates, and other official representatives of MSNJ to the reference committees indicated: Amendments to Constitution and Bylaws . . . Dr. Jehl; Reference Committee "A" . . . Dr. Kaufman; Reference Committee "B" . . . Dr. Verdon; Reference Committee "C" . . . Drs. Kustrup and Davis; Reference Committee "D" . . . Dr. Bedrick; Reference Committee "E" . . . Dr. Boylan; Reference Committee "F" . . . Drs. Mulligan and Satulsky; Reference Committee "G" . . . Dr. Patterson; Reference Committee "H" . . . Dr. Donnelly and Mr. Nevin; and Reference Committee "I" . . . Dr. Albright.

The New Jersey Delegation introduced two resolutions called for by the MSNJ House of Delegates—Resolutions #82 and #83. Resolution #82 proposed that the AMA establish a policy that marijuana is a dangerous drug, that strict penalties should be imposed for its importation or sale, and opposition to its legalization should be strongly supported. The House, on the recommendation of the Reference Committee (H), affirmed its agreement with the intent of the resolution and referred it to the Board of Trustees and to its Committee on Alcoholism and Drug Dependence with direction that a report and recommendation for AMA policy on the use of marijuana be made to the House at the 1970 Clinical Convention.

Resolution #83 urged the AMA to initiate a continuing campaign to publicize the perils of air pollution and to expand research and effective control measures. Kentucky introduced a similar resolution (#40) calling on the AMA to intensify and expand its present efforts in the control of environmental pollution. The Reference Committee (E) combined both resolutions #83 and #40 in a substitute which the House adopted. The substitute resolution mandates continued and intensified efforts on the part of the AMA to alert the public to the hazards of environmental pollution and to step up pollution control.

Other Actions of the AMA House of Delegates

Following are selected significant items from the official summaries of developments and actions taken at the 119th AMA Annual Convention. The House of Delegates considered 201 items of business, a record number, which included 61 reports and 140 resolutions.

Concerning Annual Dues . . . The House rejected the request of the Board of Trustees for an $80 increase in annual dues. It then changed the AMA Bylaws to assign the levying of annual dues to the House rather than to the Board. The House then voted a $40 dues increase, effective 1 January 1971, which will bring the yearly per capita dues to $110. The delegates also directed that explicit information supporting the need for the dues increase be disseminated by the AMA to the membership. *Doctors Satulsky and Albright spoke against the dues increase before the reference committee and Doctor Donnelly did also on the floor of the House.*

On the Subject of Abortion . . . The House had before it Report D of the Board of Trustees and five resolutions. The Board report recommended a policy that would "permit the decision to interrupt pregnancy to be made by the woman and her physician." The resolutions ranged from reaffirmation of the 1967 AMA policy to rescission of that policy and repeal of all statutory prohibitions limiting abortions.

After long debate before the reference committee and on the floor of the House, delegates finally adopted the following statement on abortion:

"Whereas, abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient, since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demands; and

"Whereas, the standards of sound clinical judgment, which, together with informed patient consent, should be determinative according to the merits of each individual case, therefore be it

"Resolved, that abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only in conformance with standards of good medical practice, and after consultation with two other physicians chosen because of their professional competence, and within the Medical Practice Act of his State; and be it further

"Resolved, that no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

Unification of the internship and residency years into a coordinated whole was agreed upon by the House in 1968 as an ultimate goal. As a means of advancing toward that goal, the House was this year called upon to consider and act upon the following statements:

"After 1 July 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole.

"After 1 July 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education."

The MSNJ House of Delegates in May 1970 recorded the Society as favoring the continuance of internships in hospitals in the communities, even though no residency programs are offered. It also directed the New Jersey AMA delegates to resist any action on the part of the AMA to the contrary.

The New Jersey Delegation carried its opposition to the floor of the House where Dr. John F. Kustrup urged the House not to adopt the statements before it. The effort was unavailing, however, and the House, by a strong vote, adopted both statements.

Mr. Nevin has prepared a more comprehensive report on the actions of the House for publication shortly in the *Membership Newsletter*. The matters that I have touched upon are, in my opinion, of special concern and interest to the Board.

I know that the Board will join with me in extending thanks to all our men who, as representatives at the Chicago convention, performed so dependably, generously, and competently. (Joseph P. Donnelly, M.D.)

Award To Jack R. Karel, M.D. . . . Extended its congratulations to Doctor Jack R. Karel, Chairman of the Committee on Emergency Medical Care, for the HEW award for "exceptional interest and dedication in promoting the Medical Self-Training Program through his Committee on Emergency Medical Care."

Board of Medical Examiners . . . Designated the following (in order of preference) as the Society's candidates to fill the vacancy on the State Board of Medical Examiners upon expiration on August 14, 1970 of the term of Edwin H. Albano, M.D.

Edwin H. Albano, M.D., East Orange
Raymond A. McCormack, Jr., M.D., Trenton
Francis E. Rieman, M.D., North Bergen

Maternal and Infant Welfare . . . Directed that a letter go to the Commission of Health stating that the Society welcomes the idea that the Department desires to use the services of a qualified member of its staff as principal field physician (see Board approved recommendation from the Committee, page 241, May 1970 issue of The Journal), but attention should be called to the fact that the original recommendation was that MSNJ should be allowed to nominate a qualified physician to serve in this capacity, and it should be pointed out that across the years the Society, through this Committee, has nominated field physicians and the Department of Health has compensated them.

Council on Public Relations . . . Appointed (until the next annual meeting) Frank R. Begen, M.D. of Teaneck to fill the vacancy on the Council on Public Relations from the 2nd District as a result of the resignation of Francis I. Tomlins, M.D.

Seminar on Continuing Medical Education . . . Authorized (at the request of MSNJ's representatives on the Steering Committee for a Department of Continuing Education) cosponsorship of an all-day seminar on October 7, 1970 organized jointly by the New Jersey College of Medicine and Dentistry and Rutgers Medical School to encourage establishment of Departments of Continuing Education in hospitals where they do not presently exist.

Utilization Review . . . Authorized the members of the Permanent Committee on Blue Cross-Blue Shield Plans to explore a request from MSP that MSNJ cooperate with Blue Cross-Blue Shield and the New Jersey Hospital Association in setting up a panel of physicians to inspect the utilization review mechanisms in New Jersey hospitals. The panel members would be compensated by Blue-Cross-Blue Shield.

Behind The Drug Scene

All drug abuse treatment programs are the result of society's attempts to control drug misuse. Prior to the legislated control upon the use and possession of various drugs, treatment related to drug abuse problems was invariably a personal decision.

Increased knowledge about drugs and the people who misuse them has generally not resulted in more effective treatment and/or care delivery. Rather we have simply changed our terminology. The drug user is rarely viewed as being simply a criminal. He is a sick person who must be rehabilitated for his own benefit and returned to contribute in a healthy manner to his community.

Treatment of any type obviously requires evaluation of the condition which is to be corrected, determination of goals, prescription of a course of specifically effective treatments, designation of the responsibilities of both the treater and the treated, and evaluation of the results of the treatment process.

This procedure is rarely if ever implemented in the treatment of drug misusers. By the time the drug misuser has come to the attention of society, he has been pre-evaluated. Depending upon who he is, he is labeled

junkie or addict or drug abuser or alcoholic or problem drinker. As treatment agents, irrespective of our professional disciplines, we are asked by society to stop the person's misuse of drugs.

Treatment most often falls into two categories: (1) chemo-therapeutic technics which rely upon substituting medicines for drugs and (2) a variety of verbal therapies. The success or failure of treatment is evaluated in terms of the achievement of a drug-free life. In recent years, employment and lack of arrests have also been added as criteria for successful treatment. The value of other positive or negative changes in behavior is rarely considered.

It should come as no surprise that given this inflexible, uncreative approach to treatment few drug-free citizens emerge from it.

Evaluation

A proper evaluation indicates what the individual's physical, psychological, and social conditions are, what strengths are present that can be mobilized or developed, and what weaknesses are present that merit repair. Evaluation should result in choosing both rehabilitation goals that are realistic for the person, and treatment modalities that relate to the person's state and the goals.

Goals

Homogeneous goals for heterogeneous groups are self-defeating. One can rarely change a person's drug behavior without changing other parts of his behavior. In this sense, drug abstinence should be a *goal* only when there are medical and/or psychiatric contraindications to continued drug use. Otherwise abstinence is a technic to achieve other goals.

Realistic goals must meet two criteria—they must be *meaningful* to and *achievable* by the person. Development of a goal system is needed if effective treatment is to be insured. Since the drug user is the focus of the treatment, he should play an active role in goal setting.

Goal	*Evaluation of Individual's Condition*
Palliation	Evaluation indicates that behavorial changes are unlikely. Person's physical and/or mental condition is too deteriorated. Palliation will permit minimizing of the pain that the person is experiencing.
Disability Limitation	Evaluation indicates that the person's level of functioning has continued to be inadequate, and increasingly so through time. The goal becomes stopping the dysfunctional behavior before it gets worse.
Rehabilitation	Evaluation indicates that the person has functioned on a healthier level at other times in his life and the strengths to do so again are present. Rehabilitation will permit the person to return to a previous level of satisfactory functioning.
Promotion	Evaluation indicates that the person has strengths and skills he has never utilized. Promotion will permit the individual to function on a level he has never functioned on before.

Treatment And Follow-up

The method of achieving goals must be directly related to the treatment modalities chosen. This obviously relates to the patient's ability to utilize the technic as well as the treatment agent's formal training in this modality, his experience with it and his attitude toward it. The concepts of continuity of care and continuity of responsibility, and the process of appropriate referral rather than "dumping operations" are crucial in treatment.

Unless a treatment program or procedure has a built in evaluation we can never really know if what we are doing is effective. The evaluation procedure should be standardized if it is at all possible so that there is greater generalizability for the drug abuse population. The criteria that are selected should include temporal flexibility. Since patterns of conventional and deviant behavior change with time, evaluation criteria must be cognizant of this.

Follow-up, also done in a standardized manner, must not fall into the trap of making conclusions from easily accessible patient populations. If a particular treatment works well or not well—with the criteria having been clearly enunciated—we must know with

which people and under what conditions it works well or not well.

Case Finding and Prevention

To the extent that we focus all our energies, money, and time on treatment, we will never catch up with the epidemic-like increase in drug abuse. We must develop methods which will lead to usable early case finding. Lastly, prevention should be based on non-drug options to the problems of living.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during July 1970:

	1970 July	1969 July
Aseptic Meningitis	2*	12
Primary Encephalitis	0*	2
Hepatitis: Total	323	158
Infectious	240	139
Serum	83	19
Malaria: Total	10	13
Military	7	13
Civilian	3	0
Meningococcal Meningitis: Total	19	3
Military	7	2
Civilian	3	1
German measles	34	6
Measles	27	52
Mumps	117	51
Salmonella	58	38
Shigella	24	20

*Delayed reports for these two diseases will follow in August report (October *Journal*).

Rocky Mountain Spotted Fever

Two cases of Rocky Mountain spotted fever have been documented by the New Jersey State Department of Health thus far this year. The first case occurred in April in a five year old girl from Burlington County. The second, confirmed in July, developed in a four year old boy who is a resident of Somerset County. This incidence is below the six cases that had been seen in New Jersey by mid-summer last year.

In the Eastern United States the dog tick (*Dermacentor variabilis*) is the vector responsible for transmission of the causative organism, *Rickettsia rickettsii,* to man. A history or physical evidence of tick bite is extremely helpful in making a diagnosis of Rocky Mountain spotted fever. The incubation period ranges between three and twelve days with an average of seven. The initial manifestations of illness are non-specific and include fever, chills, severe headache, and myalgias. The characteristic rash, which initially involves the distal portions of the extremities including the palms and soles, does not usually appear until the third or fourth day. The New Jersey State Virology Laboratory performs a complement-fixation test for Rocky Mountain spotted fever, however, complement-fixing antibodies do not appear until the second week of illness. Acute and convalescent serum specimens on all suspect cases should be submitted to the State Virology Laboratory.

If the diagnosis of Rocky Mountain spotted fever is suspected clinically, specific therapy should be initiated promptly, without waiting for the results of the laboratory studies. The tetracyclines and chloramphenicol are the antibiotics of choice, and the response to therapy is most effective when administered early in the course of the disease.

Clostridium Perfringens Gastroenteritis

An outbreak of gastroenteritis due to *Clostridium perfringens* occurred among a group of 33 persons who attended a catered affair. Twenty-five persons became ill, an attack rate of 76 per cent. The mean incubation period was 10.6 hours and mean duration of symptoms, 16.9 hours. The primary symptoms were abdominal cramps (94 per cent) and diarrhea (100 per cent). Notably absent from the symptom complex were fever and vomiting. Roast beef and gravy, with a differential attack rate of 90 per cent, were epidemiologically implicated as the offending vehicle. *Clostridium perfringens,* present in the roast beef and gravy in a concentration of 200 million organisms per gram, as well as in 21 of 22 stool specimens submitted for bacteriologic culture, was confirmed as the offending pathogen. Prolonged holding at an inadequate temperature permitted the organisms to multiply.

1970-1971

Committees and Councils

STANDING COMMITTEES

Annual Meeting

James A. Rogers, M.D., *Chairman* (1971) — Paterson
Arthur Bernstein, M.D., *Vice-Chairman* (1972) — Maplewood
Nicholas A. Bertha. M.D. (1973) — Wharton
Jerome G. Kaufman, M.D. (1971) — Maplewood
Donald C. Davidson, M.D. (1973) — Atlantic City
Robert E. Verdon, M.D. (1972) — Cliffside Park
Louis F. Albright, M.D., *Secretary* Ex-Officio — Spring Lake
James A. Hogan, M.D., *Consultant* — Newark

*Scientific Exhibits

Arthur Bernstein, M.D., *Chairman* — Maplewood
H. Irving Dunn, M.D. — Bay Head
Arthur Krosnick, M.D. — Trenton
John J. Thompson, M.D. — Caldwell
Robert E. Verdon, M.D. — Cliffside Park

Scientific Program (Sections)

Allergy

Mary B. Hall, M.D., *Chairman* — Trenton
J. Loren Rosenberg, M.D., *Secretary* — East Orange

Anesthesiology

Joanne R. Smith. M.D., *Chairman* — Glen Rock
Henry A. Connolly, Jr., M.D., *Secretary* — Summit

Cardiovascular Diseases

Leonard J. Lesniak, M.D., *Chairman* — Wayne
Joel E. Cannilla, M.D., *Secretary* — Mountain Lakes

Chest Diseases

William S. Kelhoffer, M.D., *Chairman* — Roselle Park
A. Marshall Smith, Jr., M.D., *Sec'y.* — New Brunswick

Clinical Pathology

Joseph P. Greeley, M.D., *Chairman* — Westfield
Lawrence Wilkinson, M.D., *Secretary* — Ridgewood

Dermatology

William Cohen, M.D., *Chairman* — Trenton
Roger H. Brodkin, M.D., *Secretary* — Irvington

Gastroenterology and Proctology

Herbert Z. Greenfield, M.D., *Chairman* — East Orange

General Practice

Edmund E. Jacobitti, M.D., *Chairman* — Maywood
Daniel N. Burbank, M.D., *Secretary* — Cedar Grove

Medicine

James G. Diekensheets, M.D., *Chairman* — Camden
David A. Gehring, M.D., *Secretary* — Woodbury

Obstetrics and Gynecology

Caterina Gregori, M.D., *Chairman* — Newark
Gerald J. Dolan, M.D., *Secretary* — Hillside

Ophthalmology

A. G. Portfolio, M.D., *Chairman* — Ridgewood
Raymond E. Adams, M.D., *Secretary* — Camden

Orthopedic Surgery

L. Arne Skilbred, M.D., *Chairman* — Montelair
Bernard A. Rineberg, M.D., *Sec'y* — New Brunswiek

Otolaryngology

Myles G. Turtz, M.D., *Chairman* — Cherry Hill
S. Thomas Westerman, M.D., *Secretary* — Red Bank

Pediatrics

Arthur F. Fost, M.D., *Chairman* — Belleville
Wesley Boodish, M.D., *Secretary* — Maplewood

Plastic and Reconstructive Surgery

John J. Bowe, M.D., *Chairman* — Paterson
S. Donald Maltom, M.D., *Secretary* — Morristown

Psychiatry and Neurology

Eugene V. Resniek, M.D., *Chairman* — Paramus
Daniel L. Goldstein, M.D., *Secretary* — Haekensack

Radiology

Franklin Wald, M.D., *Chairman* — Edison
David I. Kingsley, M.D., *Secretary* — Edison

Rheumatism

Joseph M. Marehesano, M.D., *Chairman* — Newark
Walter Schwarzchild, M.D., *Secretary* — Cherry Hill

Surgery

Donald K. Brief, M.D., *Chairman* — Millburn
William P. Burks, M.D., *Secretary* — Prineeton

Urology

Samuel J. Arnold, M.D., *Chairman* — Morristown
Robert E. Fullilove, Jr., M.D., *Secretary* — Newark

Credentials

Louis F. Albright, M.D., *Chairman (Secretary)* — Spring Lake
Elbert H. Pogue, M.D., *Vice-Chairman* (1971) — Elizabeth
Frank J. T. Aitken, M.D. (1972) — Bridgeton
Thaddeus Balinski, M.D., (1973) — Perth Amboy
Charles E. Gilpatrick, M.D. (1972) — Carney's Point
John W. Nieholson, III, M.D. (1973) — Moorestown
Howard J. Rosenbauer, M.D. (1971) — Haekensaek

Finance and Budget

Thomas C. DeCeeio, M.D., *Chairman* (1973) — Cliffside Park
Nieholas E. Marchione, M.D., *Vice-Chairman* (1971) — Vineland
G. Thomas DeFuseo. M.D. (1971) — Deal
David Eckstein, M.D. (1972) — Trenton
Louis G. MeAfoos, Jr., M.D. (1972) — Cherry Hill
John S. Van Mater, M.D. (1973) — New Brunswiek
Samuel J. Lloyd, M.D., *Treasurer* Ex-Officio — Trenton

Honorary Membership

Ralph M. L. Buehanan, M.D., *Chairman* (1973) — Phillipsburg
David B. Allman, M.D., *Vice-Chairman* (1971) — Brigantine
Charles H. Calvin, M.D. (1972) — Edison

Medical Defense and Insurance

William J. D'Elia, M.D., *Chairman* (1973) — Neptune City
Paul J. Kreutz, M.D., *Vice-Chairman* (1972) — Elizabeth
Irving P. Borsher, M.D. (1971) — Newark

**Subcommittee of Annual Meeting Committee*

William G. Kuhn, Jr., M.D. (1973) ... New Brunswick
William L. Palazzo, M.D. (1972) ..... Teaneck
Jesse Schulman, M.D. (1971) ..... Lakewood
Louis F. Albright, M.D., *Secretary*,
Ex-Officio ..... Spring Lake
Ernest C. Hillman, Jr., M.D., *Consultant* .. Glen Ridge
Benjamin F. Slobodien, M.D.,
Consultant ..... Perth Amboy

Medical Education

James A. Rogers, M.D., *Chairman* (1973) ... Paterson
John A. Kinczel, M.D., *Vice-Chairman*
(1971) ..... Trenton
Arthur Bernstein, M.D. (1971) ..... Maplewood
John W. Nicholson, III, M.D. (1973) ... Moorestown
William T. Snagg, M.D. (1972) ..... Camden
Edward H. Weiser, M.D. (1972) ..... Sussex
Morris H. Saffron, M.D., *Consultant* ..... Passaic

Medical Student Loan Fund

Frank J. Hughes, M.D., *Chairman*
(1971) ..... Gloucester
William Greifinger, M.D., *Vice-Chairman*
(1972) ..... Belleville
Charles H. Calvin, M.D. (1973) ..... Edison
Charles Cunningham, M.D. (1973) ..... Vineland
Joseph R. Jehl, M.D. (1971) ..... Clifton

Publication

George B. Sharbaugh, M.D., *Chairman*
(1972) ..... Trenton
James J. Fitzpatrick, M.D. (1971) ..... Trenton
Daniel B. Roth, M.D. (1973) ..... Teaneck
E. Vernon Davis, M.D., *President-Elect*,
Ex-Officio ..... Mount Holly
Louis F. Albright, M.D., *Secretary*,
Ex-officio ..... Spring Lake
Henry A. Davidson, M.D., *Editor*,
Ex-Officio ..... East Orange

Revision of Constitution and Bylaws

Lorrimer Armstrong, M.D., *Chairman*
(1971) ..... Westfield
Fred A. Mettler, M.D., *Vice-Chairman*
(1972) ..... Blairstown
Richard Berlin, M.D. (1973) ..... Teaneck
Jesse Carll, IV, M.D. (1973) ..... Bridgeton
Harold L. Colburn, Jr., M.D. (1971) .... Mount Holly
John A. Smith, M.D. (1972) ..... South River
Louis F. Albright, M.D., *Secretary*,
Ex-Officio ..... Spring Lake
Joseph M. Gannon, M.D., *Consultant* ..... Plainfield

Woman's Auxiliary

William J. Roe, M.D., *Chairman* (1972) .. Englewood
Charles Gandek, M.D., *Vice-Chairman*
(1972) ..... Edison
Ralph K. Bush, M.D. (1971) ..... Merchantville
Edward M. Coe, M.D. (1973) ..... Cranford
Jesse T. Glazier, M.D. (1973) ..... Newark
Thomas H. McGlade, M.D. (1971) ..... Camden

ADMINISTRATIVE COUNCILS

Legislation

Jesse McCall, M.D., *Chairman* (1972) ..... Newton
Henry J. Mineur, M.D., *Vice-Chairman*
(1972) ..... Cranford
Meyer L. Abrams, M.D. (1971) ..... Willingboro
A. Guy Campo, M.D. (1973) ..... Westville
Harvey P. Einhorn, M.D. (1971) ..... South Orange
John F. Franzoni, M.D. (1973) ..... Trenton
John B. Fuhrmann, M.D. (1973) ..... Flemington
Winton H. Johnson, M.D. (1972) ..... Hackensack
Louis Kosminsky, M.D. (1973) ..... Palisade
John S. Madara, M.D. (1972) ..... Salem
Daniel O'Regan, M.D. (1971) ..... Jersey City
Francis A. Pflum, M.D. (1971) ..... Asbury Park
Thomas C. DeCecio, M.D., *Chairman, Board of*
Trustees, Ex-Officio ..... Cliffside Park
E. Powers Mincher, *Legislative Analyst* ... Pennington

Medical Services

Louis K. Collins, M.D., *Chairman* (1971) .. Glassboro
Frank M. Galioto, M.D., *Vice-Chairman*
(1972) ..... Bloomfield
Donald T. Akey, M.D. (1971) ..... Metuchen
Francis J. Benz, M.D. (1971) ..... Chatham
David R. Brewer, Jr., M.D. (1972) ..... Woodbury
Arthur C. Dietrick, M.D. (1972) ..... Mount Holly
William A. Dwyer, Jr., M.D. (1973) ..... Paterson
David Flinker, M.D. (1972) ..... Moorestown
Karl T. Franzoni, M.D. (1973) ..... Trenton
Robert E. Fullilove, Jr., M.D. (1973) ..... Newark
Robert S. Gamon, Jr., M.D. (1971) ..... Cherry Hill
James S. Todd, M.D. (1973) ..... Ridgewood
E. Vernon Davis, M.D., *President-Elect*,
Ex-Officio ..... Mount Holly
Nicholas E. Marchione, M.D., *Consultant* .. Vineland

Mental Health

Robert S. Garber, M.D., *Chairman*
(1972) ..... Belle Mead
Edward A. Schauer, M.D., *Vice-Chairman*
(1973) ..... Farmingdale
Miles E. Drake, M.D. (1973) ..... Vineland
Evelyn P. Ivey, M.D. (1972) ..... Farmingdale
Clarence W. Jaggard, M.D. (1972) ..... Woodbury
Arnold Kallen, M.D. (1971) ..... Livingston
Seymour F. Kuvin, M.D. (1973) ..... Livingston
Henry J. Mineur, M.D. (1971) ..... Cranford
J. Lloyd Morrow, M.D. (1971) ..... Passaic
Eugene V. Resnick, M. D. (1971) ..... Paramus
John R. Rushton, III, M.D. (1973) ..... Camden
Martin H. Weinberg, M.D. (1972) ..... Trenton
Nicholas A. Bertha, M.D., *Immediate*
Past-President, Ex-Officio ..... Wharton

Public Health

Robert G. Salasin, M.D., *Chairman*
(1972) ..... North Wildwood
Kendrick P. Lance, M.D., *Vice-Chairman*
(1973) ..... Paterson
Roslyn Barbash, M.D. (1973) ..... Teaneck
William M. Chase, M.D. (1973) ..... Newark
George L. Erdman, M.D. (1971) ..... Summit
Anthony P. DeSpirito, M.D. (1972) ... Neptune City
Henry L. Drezner, M.D. (1971) ..... Trenton
Rudolph G. Matflerd, M.D. (1971) ... New Brunswick
Thomas F. McLaughlin, M.D. (1973) ..... Metuchen
John J. Pastore, M.D. (1972) ..... Vineland
Francis E. Rieman, M.D. (1972) ..... Jersey City
Frederick C. Steller, M.D. (1971) ..... Spring Lake
William J. D'Elia, M.D., *1st Vice-President*,
Ex-Officio ..... Neptune City
James R. Cowan, Sr., M.D., *Consultant* .... Trenton

Public Relations

John J. Crosby, Jr., M.D., *Chairman* (1972) .. Jersey City
John P. Kengeter, M.D., *Vice-Chairman*
(1971) ..... Toms River
Frank R. Begen (1971) ..... Teaneck
William N. Evans, M.D. (1973) ..... Mount Holly
Robert Holman, M.D. (1972) ..... Pompton Plains

S. William Kalb, M.D. (1971) ..... Newark
Josiah C. McCracken, Jr., M.D. (1972) ..... Ventnor
John J. McGuire, M.D. (1973) ..... Newark
William P. Mulford, M.D. (1971) ..... Beverly
John A. Sakson, M.D. (1971) ..... Yardley, Pa.
Howard D. Slobodien, M.D. (1973) ..... Perth Amboy
Ford C. Spangler, M.D. (1973) ..... Salem
Matthew E. Boylan. M.D., *2nd Vice President,* Ex-Officio ..... Jersey City

SPECIAL COMMITTEE TO THE COUNCIL ON MEDICAL SERVICES

Occupotional Health, Workmen's Compensation and Rehabilitation

Joseph A. Lepree, M.D., *Chairman* ..... Elizabeth
Joshua N. Zimskind, M.D., *Vice-Chairman* ..... Trenton
Delma W. Caldwell, M.D. ..... Linden
James F. Collier, M.D. ..... Haddonfield
Elmer J. Elias, M.D. ..... Trenton
John W. Holdcraft, M.D. ..... Woodbury
Dominic A. Kujda, M.D. ..... Butler
Carl A. Maxwell, M.D ..... Phillipsburg
William D. Van Riper, M.D. ..... New Brunswick
Mathilda R. Vaschak, M.D. ..... New Brunswick
Nelson C. Walker, M.D. ..... Hackensack
Ralph A. Young, M.D. ..... Linden
Jarvis A. Smith, M.D., *Consultant* ..... Trenton

SPECIAL COMMITTEES TO THE COUNCIL ON MENTAL HEALTH

Alcoholism

George Rogers, M.D., *Chairman* ..... Camden
Robert Albahary, M.D. ..... New Brunswick
David Canavan, M.D. ..... Oakland
Joseph P. Greeley, M.D. ..... Westfield
Allen A. Parry, M.D. ..... Madison

Drug Abuse

Henry A. Davidson, M.D., *Chairman* ..... East Orange
Mary Ann Bartusis, M.D. ..... Trenton
Hans W. Freymuth, M.D. ..... Trenton
Granville Jones, M.D. ..... Summit
Harry Le Fever, M.D. ..... Cherry Hill
Edward A. Wolfson, M.D. ..... Glen Rock

Emotional Disorders of Childhood and Adolescence

Eugene V. Resnick, M.D., *Chairman* ..... Paramus
Jay W. Fidler, M.D. ..... Plainfield
Harvey Hammer, M.D. ..... Morristown
Bradford Judd, M.D. ..... Shrewsbury
Joseph J. Kline, M.D. ..... Trenton
Alan Kulick, M.D. ..... Millville

Mental Retardation

Miles E. Drake, M.D., *Chairman* ..... Vineland
Eugene Revitch, M.D. ..... Plainfield
Catherine Spears, M.D. ..... Chatham
Robert A. Weinstein, M.D. ..... Newton
Harry Yolken, M.D. ..... Paterson

Seizures

J. Lloyd Morrow, M.D., *Chairman* ..... Passaic
Richard A. Nelson, M.D. ..... Neptune City
Josiah J. Pegues, M.D. ..... Mount Holly
Ira S. Ross, M.D. ..... South Orange
Walter Scheuerman, M.D. ..... Trenton

SPECIAL COMMITTEES TO THE COUNCIL ON PUBLIC HEALTH

Cancer Control

John L. Olpp, M.D., *Chairman* ..... Englewood
Harold L. Colburn, Jr., M.D. ..... Mount Holly
Roy T. Forsberg, M.D. ..... Westfield
Sherman Garrison, M.D. ..... Bridgeton
John A. Ianacone, M.D. ..... Paterson
Warren H. Knauer, M.D. ..... Hillside
Bernard Koven, M.D. ..... Englewood
Sylvan E. Moolten, M.D. ..... Highland Park

Child Health

William J. Farley, M.D., *Chairman* ..... Nutley
Robert E. Jennings, M.D. ..... South Orange
Glenn P. Lambert, M.D. ..... Flemington
Thomas P. McFarland, Jr., M.D. ..... Mays Landing
Bernard N. Millner, M.D. ..... Trenton
Milton Prystowsky, M.D. ..... Nutley
Robert D. Rento, M.D. ..... Clifton
William L. Rumsey, Jr., M.D. ..... Elizabeth
Gene N. Schraeder, M.D. ..... Pleasantville
Sidney Tucker, M.D. ..... Perth Amboy

Conservation of Vision, Hearing, and Speech

Frank B. Vanderbeek, M.D., *Chairman* ..... Paterson
Bernard A. Balsis, M.D. ..... Trenton
Paul Chodosh, M.D. ..... Hillside
Alfonse A. Cinotti, M.D. ..... Jersey City
Ralph L. Dicker, M.D. ..... Dover
Samuel Diskan, M.D. ..... Atlantic City
Joseph H. Kler, M.D. ..... New Brunswick
Oram R. Kline, M.D. ..... Camden
Ralph E. Siegel, M.D. ..... Perth Amboy
Ralph A. Skowron, M.D. ..... Cherry Hill
D. Blair Sulouff, M.D. ..... Morristown
Anthony M. Sellitto, M.D., *Consultant* ..... South Orange

Environmental Health

Roslyn Barbash, M.D., *Chairman* ..... Teaneck
Rudolph T. DePersia, M.D. ..... Gibbstown
Mary B. Hall, M.D. ..... Trenton
E. Spencer Paisley, M.D. ..... Haddon Heights
Frank L. Rosen, M.D. ..... Maplewood
Edward E. P. Seidmon, M.D. ..... Plainfield
William I. Weiss, M.D. ..... Livingston
Meyer T. Weissman, M.D. ..... Elizabeth

Maternal & Infant Welfare

John D. Preece, M.D., *Chairman* ..... Trenton
Robert A. Cosgrove, M.D. ..... Jersey City
Edward Foord, M.D. ..... Burlington
Charles D. Foster, III, M.D. ..... Pitman
John D. Franzoni, M.D. ..... Trenton
Calvin Hahn, M.D. ..... Vineland
Herbert F. Johnson, M.D. ..... Camden
Walter P. Peter, Jr., M.D. ..... Plainfield
Daniel B. Roth, M.D. ..... Teaneck
Harold Schwartz, M.D. ..... Millburn
Jack E. Shangold, M.D. ..... Perth Amboy
Leopold E. Thron, M.D. ..... Paterson
Bernard N. Millner, M.D., *Consultant* ..... Trenton

SPECIAL COMMITTEES

Emergency Medical Care

Jack R. Karel, M.D., *Chairman* ..... Hillside
R. Winfield Betts, M.D., *Vice-Chairman* ..... Medford
Clifford B. Blasi, M.D. ..... Jersey City
Charles Campbell, M.D. ..... Hackensack

Frank Dresdale, M.D. ..... Plainfield
John A. Flood, Jr., M.D. ..... Trenton
Dorson S. Mills, M.D. ..... Elmer
Frank R. Schell, M.D. ..... Butler
Marie A. Sena, M.D., *Consultant* ..... Linden

Medicine and Religion

Luke A. Mulligan, M.D., *Chairman* ..... Leonia
John J. Bedrick, M.D. ..... Bayonne
Charles H. Calvin, M.D. ..... Edison
John S. Madara, M.D. ..... Salem
Thomas H. McGlade, M.D. ..... Camden

Project Hope and Vietnam

Thomas C. DeCecio, M.D., *Chairman* ... Cliffside Park
Harold L. Colburn, Jr., M.D. ..... Mount Holly
J. Leonard Greif, M.D. ..... Dover

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., *Chairman* ... Vineland
Richard R. Chamberlain, M.D. ..... Maplewood
Albert F. Moriconi, M.D. ..... Trenton

Traffic Safety

Irwin S. Smith, M.D., *Chairman* ..... Willingboro
Hillel Ben-Asher, M.D. ..... Morristown
Arnold N. Constad, M.D. ..... Springfield
John J. Crosby, Jr., M.D. ..... Jersey City
William L. Sprout, M.D. ..... Salem
Frank B. Vanderbeek, M.D. ..... Paterson

1970-1971 SPECIAL COMMITTEES SPECIAL/LIAISON REPRESENTATIVES

Abortion Law Study Commission

(Nine-member legislative commission to study statutes relating to abortion and the problem of illegal abortions in New Jersey.)
Hannah Seitzick-Robbins, M.D. ..... Trenton

Academy of Medicine of New Jersey

(1) Board of Trustees/Liaison Committee
(Liaison requested by Academy — 6/19/66)
A. Guy Campo, M.D. ..... Westville
David Eckstein, M.D. ..... Trenton
James A. Rogers, M.D. ..... Paterson
(2) Post-Graduate Medical Education Study Committee
(Representative requested by Academy — 11/15/64)
James A. Rogers, M.D., *Chairman, Committee on Medical Education* . Paterson
John A. Kinczel, M.D., *Vice-Chairman, Committee on Medical Education* ... Trenton

American Medical Association-Education Research Foundation

(Liaison requested by AMA — 10/7/51)
Frank J. Hughes, M.D., *Chairman, Committee on Medical Student Loan Fund* ..... Gloucester

Audit Review Committee (1969-1970 Audit)

(Appointed annually by Board to review previous year's audit)
Louis F. Albright, M.D., *Chairman* ..... Spring Lake
Nicholas A. Bertha, M.D. ..... Wharton
Edward G. Bourns, M.D. ..... Westfield
William J. D'Elia, M.D. ..... Neptune City
I. Edward Ornaf, M.D. ..... Camden
Consultants:
Samuel J. Lloyd, M.D., *Treasurer* ..... Trenton
Thomas C. DeCecio, M.D., *Chairman, Finance and Budget Committee* ..... Cliffside Park

Bicentennial History

(Committee appointed to expedite distribution of history — 5/12/67)
Emanuel M. Satulsky, M.D., *Chairman* ..... Elizabeth
Mr. Richard I. Nevin, *Executive Director* .... Trenton

Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Association — 4/25/69)
David Eckstein, M. D. ..... Trenton

Blood Bank Commission of New Jersey

(1) Formation of Commission authorized by 1953 House of Delegates
Authorized agent of MSNJ in approved Blood Bank Programs
(2) Appointment of two representatives requested by Commission — 4/5/54
Jerome G. Kaufman, M.D. ..... Maplewood
John J. Torppey, M.D. ..... Newark

Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of committee requested by MSP — 4/16/60)
Thomas C. DeCecio, M.D. *Chairman, Board of Trustees* ..... Cliffside Park
Emanuel M. Satulsky, M.D., *President* ..... Elizabeth
Mr. Richard I. Nevin, *Executive Director* ... Trenton
Equal representation from:
Medical Service Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Board of Control, Department of Institutions and Agencies

(Appointed by Governor for 8-year term)
Frank J. Hughes, M.D., (June 1971) ..... Gloucester

Board of Nursing, New Jersey State

(Liaison requested by Board of Nursing — 11/21/65)
Jesse McCall, M.D. ..... Newton

Bookkeeping, Accounting, and Billing System, *Ad Hoc* Committee to Establish a Statewide Automated

(Established at the request of the 1970 House of Delegates)
Louis F. Albright, M.D., *Secretary* ..... Spring Lake
Samuel J. Lloyd, M.D., *Treasurer* ..... Trenton
Thomas C. DeCecio, M.D., *Chairman, Finance and Budget Committee* ..... Cliffside Park
Mr. Robert H. Lambert, *Business Manager* .. Trenton

Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of Law and Public Safety — 9/61)
Board of Trustees

Cardiac Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic Safety — 9/17/61 . . . appointed by Director of Motor Vehicles)
Jerome G. Kaufman, M.D., *Chairman* .... Maplewood
James G. Kehler, M.D. ..... Woodbury
Jesse McCall, M.D. ..... Newton
John C. Wood, M.D. ..... Trenton

Chamber of Commerce Legislative Conferences

(Invited by Chamber — 1/15/61)
Mr. Richard I. Nevin, *Executive Director* ... Trenton

Chronic Sick State Advisory Council

(Commissioner of Health requested MSNJ submit names to Governor — 10/16/60 . . . appointed by Governor for 3-year term)
David Eckstein, M.D. (1971) ..... Trenton

Civil Defense Organization, Liaison with State

(Liaison established by MSNJ — 5/22/55)

Jack R. Karel, M.D. *Chairman, Committee on Emergency Medical Care* ..... Hillside

Comprehensive Health Planning Agency

(Liaison requested by the Comprehensive Health Planning Agency 12/16/69) MSNJ members to serve on the following committees:

Irving P. Borsher, M.D., *Health Care Costs Committee* ..... Newark

Arthur Bernstein, M.D., *Medicaid Committee* ..... Maplewood

James A. Rogers, M.D., *Medical Education Facilities Committee* ..... Paterson

Crippled Children Commission, State

(Appointed by Governor for a 5-year term)

Frederick G. Dilger, M.D. (May 1971) ... Hackensack

Diabetes Detection Drive

(Liaison representative for annual drive — co-sponsored by State Department of Health, New Jersey Diabetes Association, and MSNJ — appointed at request of Commissioner of Health — 5/16/54)

John J. Torppey, M.D. ..... Newark

Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP — 8/21/60 — Quorum: 4 members)

1st District —
Ralph M. L. Buchanan, M.D., *Chairman* ..... Phillipsburg
Robert F. Zimmerman, M.D. ..... Morristown

2nd District —
John J. Bedrick, M.D. ..... Bayonne
Robert A. Cosgrove, M.D. ..... Jersey City

3rd District —
John S. VanMater, M.D. ..... New Brunswick
John A. Kinczel, M.D. ..... Trenton

4th District —
John C. Clark, M.D. ..... Asbury Park
Robert S. Gamon, Jr., M.D. ..... Cherry Hill

5th District —
A. Guy Campo, M.D. ..... Westville
Nicholas E. Marchione, M.D. ..... Vineland

Education, State Department of

(Liaison requested by the Assistant Commissioner of Education — 9/21/58)

William J. Farley, M.D., *Chairman, Special Committee on Child Health* ..... Nutley

Emotionally Disturbed Child, Advisory Council to Department of Education

(Liaison requested by the Department of Education — 10/28/68)

William J. Farley, M.D. ..... Nutley

Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles — 7/29/66)

J. Berkeley Gordon, M.D. ..... Rumson

Executive Committee

(Provided in the Bylaws, Chapter IV, Section 5 (b))

Emanuel M. Satulsky, M.D., *President* .... Elizabeth
E. Vernon Davis, M.D., *President-Elect* .. Mount Holly
William J. D'Elia, M.D., *First Vice-President* ..... Neptune City
Matthew E. Boylan, M.D., *Second Vice-President* ..... Jersey City
Thomas C. DeCecio, M.D., *Chairman Board of Trustees* ..... Cliffside Park

Eye Medication, Conference Committee on the Control of

(Established by Board of Trustees — 4/20/69)

Samuel J. Lloyd, M.D., *Chairman, Representative of the Board of Trustees* ..... Trenton
Jesse McCall, M.D., *Chairman, Council on Legislation* ..... Newton
Henry J. Mineur, M.D., *Vice-Chairman, Council on Legislation* ..... Cranford
Frank B. Vanderbeek, M.D., *Chairman, Committee on Conservation of Vision, Hearing, and Speech* ..... Paterson
D. Blair Sulouff, M.D., *Member, Committee on Conservation of Vision, Hearing, and Speech* ..... Morristown
Mr. E. Powers Mincher, *Legal Counsel* .. Pennington
Mr. Richard I. Nevin, *Executive Director* ... Trenton
Mr. Vincent A. Maressa, *Executive Assistant* .. Trenton
Representatives of the New Jersey Academy of Ophthalmology and Otolaryngology
Alfonse A. Cinotti, M.D. ..... Jersey City
John Scillieri, M.D. ..... Paterson
Reginald J. Raban, M.D. ..... Cherry Hill

Fluoridation, Joint Committee on

(Established at request of State Department of Health)

Edwin H. Albano, M.D. ..... East Orange
Rudolph G. Matflerd, M.D. ..... New Brunswick
Equal representation from:
State Department of Health
New Jersey State Dental Society

Headquarters, Investigation of Future

(Committee established by Board — 6/19/66)

Nicholas A. Bertha, M.D., *Chairman* ..... Wharton
Samuel J. Lloyd, M.D. ..... Trenton
Emanuel M. Satulsky, M.D. ..... Elizabeth

Health Careers Service, New Jersey

(Physician representation established by Board of Trustees 7/20/69)

Karl T. Franzoni, M.D. ..... Trenton

Health Careers Service, Resource Persons to New Jersey

(Liaison established at request of Health Careers Service — 7/19/64)

Presidents of Component Societies

Health Facilities Planning Council

(MSNJ invited to nominate 3 members for the Board of Trustees — 2/16/64 . . . appointed by Council to serve for a 3-year term)

Louis F. Albright, M.D. (1973) ..... Spring Lake
John F. Kustrup, M.D. (1972) ..... Trenton
Jesse McCall, M.D. (1971) ..... Newton

Health Insurance Conference

(Committee established at request of Health Insurance Council — 3/24/57)

Jerome G. Kaufman, M.D., *Chairman* .... Maplewood
Charles L. Cunniff, M.D. ..... Jersey City
Emanuel M. Satulsky, M.D., *President* .. Elizabeth
E. Vernon Davis, M.D., *President-Elect* . Mount Holly
William J. D'Elia, M.D., *First Vice-President* ..... Neptune City
Matthew E. Boylan, M.D., *Second Vice-President* ..... Jersey City
Mr. Richard I. Nevin, *Executive Director* . Trenton

Health, State Department of
(Liaison requested by Commissioner of Health — 6/6/54)
Robert G. Salasin, M.D., *Chairman, Council on Public Health* ..... North Wildwood

Heart Disease, Cancer, and Stroke
University City Science Center, Philadelphia
(Established at invitation of University City Science Center — 12/65)
Louis K. Collins, M.D. ..... Glassboro

Historian-Archivist
(Created at the suggestion of the Executive Director — 1/13/57)
Morris H. Saffron, M.D. (Appointed 5/67) .... Passaic

Hospital Association, New Jersey
(Invitation extended to Executive Director to serve on the Board of Trustees — 12/17/67)
Mr. Richard I. Nevin, *Executive Director* .... Trenton

Hospital Advisory Council, State Department of Institutions and Agencies
(Appointed by the Board of Control for a 4-year term)
Luke A. Mulligan, M.D. (December 1972) .... Leonia

House Maintenance, Staff Policies, and Personnel Relations
(Special Committee created by Board of Trustees — 9/21/58)
Emanuel M. Satulsky, M.D., *President (Chairman)* ..... Elizabeth
E. Vernon Davis, M.D., *President-Elect* .. Mount Holly
Louis F. Albright, M.D., *Secretary* ..... Spring Lake
Samuel J. Lloyd, M.D., *Treasurer* .... Trenton
Thomas C. DeCecio, *Chairman, Board of Trustees and Chairman, Committee on Finance and Budget* ..... Cliffside Park
Mr. Richard I. Nevin, *Executive Director* .... Trenton

Industrial Safety Board, New Jersey
(Appointed by the Governor — 10/16/66)
Joseph A. Lepree, M.D.(7/1/71) ..... Elizabeth

Institutions and Agencies, State Department of
(Liaison established 7/16/61)
Frank J. Hughes, M.D. ..... Gloucester

Intra-Hospital Infections, Joint Committee on
(Established at request of Commissioner of Health — 4/8/62)
Edwin H. Albano, M.D., *Chairman* ..... East Orange
Lawrence Gilbert, M.D. ..... Newark
Thomas K. Rathmell, M.D. ..... Trenton
Eugene H. Kain, M.D. ..... Camden
Equal representation from:
State Department of Health
New Jersey Hospital Association
New Jersey State Nurses' Association

JEMPAC, Conference Committee with
(Established at request of JEMPAC — 6/25/67)
Jesse McCall, M.D., *Chairman, Council on Legislation* .... Newton
Louis K. Collins, M.D., *Chairman, Council on Medical Services* ... . Glassboro
Matthew E. Boylan, M.D., *Second Vice-President* .... Jersey City

Judiciary and Bar, Conference Committee on Inter-Relations with the
(Established at invitation of Supreme Court—11/17/63)
Louis F. Albright, M.D. ..... Spring Lake
Nicholas A. Bertha, M.D. ..... Wharton
E. Vernon Davis, M.D. .... Mount Holly
William J. D'Elia, M.D. ..... Neptune City
Jerome G. Kaufman, M.D. ..... Maplewood
Samuel J. Lloyd, M.D. ..... Trenton
Nicholas E. Marchione, M.D. ..... Vineland
Jesse McCall, M.D. ..... Newton
Emanuel M. Satulsky, M.D., *President, Ex-Officio* .. .. Elizabeth
Mr. E. Powers Mincher, *Legal Counsel* ... Pennington
Mr. Richard I. Nevin, *Executive Director* .... Trenton
Mr. Vincent A. Maressa, *Executive Assistant* .. Trenton
Equal representation from:
Supreme Court Committee on Relations with the Medical Profession

Legal Documents, Committee on Extension to Interns and Residents of Power to Sign Certain
(Established at request of 1969 House of Delegates)
Nicholas A. Bertha, M.D., *Chairman* . ..... Wharton
Henry J. Mineur, M.D. ..... Cranford
Emanuel M. Satulsky, M.D. ..... Elizabeth

Legislation
(1) Federal Keymen
(Mechanism established by MSNJ — 4/4/54 . . . to serve as official intermediaries between MSNJ and the Federal legislators)
15 Congressional District Keymen
1 Senatorial Keyman
(2) State Keymen
(Mechanism established by MSNJ — 7/13/52)
Keymen in 15 Senatorial Districts/21 Component Societies

Medicaid Commission, Medical Advisory Council of the State
(Established at invitation of the State Medicaid Commission)
Louis K. Collins, M.D. .... Glassboro

Medicaid, Negotiating Committee For
(Established by Board of Trustees to work with the State Medicaid Commission — 12/22/68)
Emanuel M. Satulsky, M.D., *President* ..... Elizabeth
E. Vernon Davis, M.D., *President-Elect* Mount Holly
Louis K. Collins, M.D., *Chairman, Council on Medical Services* ..... Glassboro
Associate Members:
Jesse McCall, M.D., *Chairman, Council on Legislation* .. .. Newton
Henry J. Mineur, M.D., *Vice-Chairman, Council on Legislation* ..... Cranford
Frank M. Galioto, M.D., *Vice-Chairman, Council on Medical Services* ..... Bloomfield
Francis J. Benz, M.D., *Representative of 1st Judicial District* ... . Chatham
Karl T. Franzoni, M.D., *Representative of 3rd Judicial District* ... . Trenton
Robert S. Gamon, Jr., M.D., *Representative of 4th Judicial District* ..... Cherry Hill

Medicaid, New Jersey (Citizens) Committee for
(Established at request of organization — 4/21/68)
Louis K. Collins, M.D. ..... Glassboro

Medicaid Peer Review Committee
(Established by Board of Trustees 4/19/70 at the request of the Department of Institutions and Agencies. The function of the Committee will be to act upon inquiries and/or complaints originating either with the administrators of the Medicaid Program or with physicians serving under the program.)
1st District —
Nicholas A. Bertha, M.D. ..... Wharton
2nd District —
Ambrose P. Boyle, Jr., M.D. ..... Fort Lee
3rd District —
David Eckstein, M.D. ..... Trenton

4th District —
Emanuel Abraham, M.D. ... Asbury Park
5th District —
Mario Pastore, M.D. ... Vineland

Medicaid Program, Medical Advisory Committee to the
(Appointment of four representatives requested by Department of Institutions and Agencies — 6/12/69)
Donald P. Burt, M.D. ... Morristown
Arthur C. Dietrick, M.D. ... Mount Holly
John D. Franzoni, M.D. ... Trenton
Samuel J. Lloyd, M.D. ... Trenton

Medical Advances and Planning, Steering Committee on
(Established by Board of Trustees 5/15/70. This Committee will be charged with the duty of organizing a statewide Department on Medical Advances, which, hopefully, would succeed in stimulating the interest of physicians, coordinating existing activities, and eliminating needless duplications in program offerings.)
Nicholas A. Bertha, M.D. ... Wharton
James A. Rogers, M.D. ... Paterson
2 Representatives from the Directors of Medical Education
2 Representatives from each of the medical schools

Medical Assistants, New Jersey Association of
(Liaison requested by Association — 9/15/63)
Aaron J. Heisen, M.D. ... Trenton

Medical-Hospital-Nursing Conference (Tri-Partite)
(Liaison established by MSNJ — 1/13/57)
Emanuel M. Satulsky, M.D., *President* ... Elizabeth
E. Vernon Davis., M.D., *President-Elect* ... Mount Holly
Nicholas A. Bertha, M.D., *Immediate Past-President* ... Wharton
Mr. Richard I. Nevin, *Executive Director* ... Trenton
Equal representation from:
New Jersey Hospital Association
New Jersey State Nurses' Association

Medical Liaison Committees
(High-level conference groups for discussion and consideration of items of mutual interest)
Emanuel M. Satulsky, M.D., *President* ... Elizabeth
E. Vernon Davis, M.D., *President-Elect* ... Mount Holly
Nicholas A. Bertha, M.D., *Immediate Past-President* ... Wharton
Mr. Richard I. Nevin, *Executive Director* ... Trenton
(Where number of representatives from other organization is larger than number of MSNJ representatives, the latter will be increased from the Presidential Officers to equal the former.)
(1) Medical-Dental
(Liaison requested by the Dental Society—6/10/51)
(2) Medical-Hospital
(Liaison established by MSNJ — 10/25/53)
(3) Medical-Legal
(Liaison established by MSNJ — 10/25/53)
(4) Medical-Nursing
(Liaison established by MSNJ — 4/4/54)
(5) Medical-Osteopathic
(Liaison requested by Osteopathic Association — 9/17/61)
(6) Medical-Pharmaceutical
(Liaison established by MSNJ — 7/26/53)

Medical School in South Jersey, Committee to Assist in the Implementation of Legislation to Establish a
(Established by Board — 5/17/67 — Appointments by President)
Louis K. Collins, M.D., *Chairman* ... Glassboro
A. Guy Campo, M.D. ... Westville
Sherman Garrison, M.D. ... Bridgeton
Frank J. Hughes, M.D. ... Gloucester
Jerome G. Kaufman, M.D. ... Maplewood
John F. Kustrup, M.D. ... Trenton
Fred A. Mettler, M.D. ... Blairstown
James A. Rogers, M.D. ... Paterson

Medical Schools in New Jersey, *Ad Hoc* Committee on Development of
(Established by Board — 9/20/64)
Emanuel M. Satulsky, M.D., *President* ... Elizabeth
E. Vernon Davis, M.D., *President-Elect* ... Mount Holly
Sherman Garrison, M.D. ... Bridgeton
Jerome G. Kaufman, M.D. ... Maplewood
Fred A. Mettler, M.D. ... Blairstown
James A. Rogers, M.D. ... Paterson

Medical-Surgical Plan Board of Trustees
(Provided in MSP Bylaws)
Emanuel M. Satulsky, M.D., *President* ... Elizabeth

Medicare, Committee on Utilization of Physicians' Services under Part B
(Established at request of 1969 House of Delegates)
Nicholas A. Bertha, M.D., *Chairman* ... Wharton
John F. Kustrup, M.D. ... Trenton
Emanuel M. Satulsky, M.D. ... Elizabeth

Medicare Claims Inquiry Committee, Joint
(Established by Board of Trustees 11/16/69 to provide physicians, who feel their fees have been arbitrarily reduced, or who have other bases of dissatisfaction, with a forum for discussion.)
Representing The Medical Society of New Jersey:
Emanuel M. Satulsky, M.D., *President*
E. Vernon Davis, M.D., *President-Elect*
Louis F. Albright, M.D.
Donald T. Akey, M.D.
Mr. Richard I. Nevin, *Executive Director*

Representing the Fiscal Intermediary:
Mr. William C. White, Jr., C.L.U., *Vice President*
Mr. Everett J. Park, F.L.M.I., *General Manager*
James E. Brennan, M.D., *Medical Director*
Mr. Wilfred I. Meyers, *Associate Director*
Mr. Philip H. Thomas, *Associate General Manager*

Medicare Law (P.L. 89-97)
(Assigned by the Board — 10/17/65 as indicated below)
(1) Over-all responsibility to study and provide recommendations concerning the Medicare Program
Council on Medical Services
Consultants to the Council on Medical Services:
Emanuel M. Satulsky, M.D., *President* ... Elizabeth
E. Vernon Davis, M.D., *President-Elect* ... Mount Holly
Jesse McCall, M.D., *Chairman Council on Legislation* ... Newton
Robert G. Salasin, M.D., *Chairman, Council on Public Health* ... North Wildwood
Frank J. Hughes, M.D., *Member, New Jersey Board of Control* ... Gloucester
(2) Liaison representative to State Department of Health
(Established by MSNJ — 1/16/66)
David Eckstein, M.D. ... Trenton
(3) Liaison representative to State Department of Institutions & Agencies
(Established by MSNJ — 1/16/66)
Francis J. Benz, M.D ... Chatham
Louis K. Collins, M.D., *Chairman, Council on Medical Services* ... Glassboro
Mr. Vincent A. Maressa, *Executive Assistant* ... Trenton
(4) Home-Hospital-Nursing Care
(Liaison established by MSNJ — 3/20/66)
Matthew E. Boylan, M.D. ... Jersey City

Membership Directory

(Special committee established by Board — 11/19/61)
Louis F. Albright, M.D., *Chairman* ..... Spring Lake
Robert C. Anderson, M.D. ..... Newark
John J. Bedrick, M.D. ..... Bayonne
Matthew E. Boylan, M.D. ..... Jersey City
George B. Sharbaugh, M.D. ..... Trenton
Mr. Richard I. Nevin, *Executive Director* .... Trenton
Mr. Robert H. Lambert, *Business Manager* . Trenton

Motor Vehicles, State Division of

(Liaison established at the request of the Division — 4/16/61)
Irwin S. Smith, M.D., *Chairman, Committee on Traffic Safety* ..... Willingboro

Neurological Diseases, Advisory Council to New Jersey Consultation Service for Convulsive Disorders

(Liaison established — 7/19/64)
Robert S. Garber, M.D. ..... Belle Mead

New Jersey College of Medicine and Dentistry, Student AMA

(Liaison requested by New Jersey Chapter — 1/26/60)
George E. Barbour, M.D. ..... Somerville

Nursing Education and Recruitment, Permanent Committee on

(Established by direction of 1963 House of Delegates)
Jesse McCall, M.D., *Chairman* ..... Newton
George E. Barbour, M.D. ..... Somerville
William P. Mulford, M.D. ..... Beverly
Lewis E. Savel, M.D. ..... South Orange
Mr. Richard I. Nevin, *Executive Director* .... Trenton
Equal representation from:
New Jersey Hospital Association
New Jersey League for Nurses
New Jersey State Nurses' Association
Administrators of Nursing Schools
Advisors (2) from State Department of Education

Nutrition Council, New Jersey

(Liaison established by MSNJ — 12/19/54)
Harvey P. Einhorn, M.D. ..... South Orange

Ochampus (Office for the Civilian Health and Medical Program of the Uniformed Services)

(1) Fiscal Agent
(Designated upon request of MSP — 7/21/63)
Medical-Surgical Plan of New Jersey
(2) Special Committee on
(Established by MSNJ — 9/9/56)
Nicholas A. Bertha, M.D., *Chairman* .. Wharton
George E. Barbour, M.D. ..... Somerville
Thomas C. DeCecio, M.D. ..... Cliffside Park
John F. Kustrup, M.D. ..... Trenton

Parents and Teachers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child Health — 12/20/64)
Joseph R. Jehl, M.D. ..... Clifton

Pension Plan, Special Committee on

(Established by Board — 5/22/55 . . . Duties outlined in Article III of Pension Plan Agreement)
Thomas C. DeCecio, M.D., *Chairman, Committee on Finance and Budget* ... Cliffside Park
Emanuel M. Satulsky, M.D., *Chairman, Special Committee on House Maintenance, Staff Policies, and Personnel Relations* ..... Elizabeth
Samuel J. Lloyd, M.D., *Treasurer* ..... Trenton

Public Health Association, New Jersey

(1) Membership authorized by Board — 11/15/59
Joseph R. Jehl, M.D. *(Delegate)* .. Clifton
Mr. Richard I. Nevin *(Alternate)* ..... Trenton
(2) Animal (Medical) Research
(Liaison representative requested — 4/17/66)
Edwin H. Albano, M.D. ..... East Orange
(3) Medical Care Committee
(Association requested physician to serve as chairman of its Medical Care Committee — 2/24/65)
John J. Bedrick, M.D. ..... Bayonne

Public Health Council, State Department of Health

(Nominations for appointment by Governor requested — 9/20/64)
Henry L. Drezner, M.D. ..... Trenton

Quackery, Committee on

(Established at the request of the AMA — 11/15/64)
Henry J. Mineur, M.D., *Chairman* ..... Cranford
Charles B. Norton, M.D. ..... Woodstown
James S. Todd, M.D. ..... Ridgewood

Radiation Protection Commission, Consultant to New Jersey

(Nomination for appointment to Commission requested — 7/18/65)
Bernard M. Schnur, M.D. ..... Trenton

Radiation Protection Commission, New Jersey

(Two consultants in nuclear medicine requested by the Commission 11/66)
Frank Schell, M.D. ..... Paterson
John Thompson, M.D. ..... Caldwell

Regional Planning Council, Philadelphia Medical Library Committee

(Appointment of representative requested by Library Committee — 8/20/67)
Sherman Garrison, M.D. ..... Bridgeton

Rehabilitation Commission, New Jersey State

(Liaison requested by MSNJ's Committee on Rehabilitation — 5/65)
Carl A. Maxwell, M.D. ..... Phillipsburg

Safety Council, New Jersey State

(Provided in Council Bylaws)
Emanuel M. Satulsky, M.D., *President* .... Elizabeth
Joseph A. Lepree, M.D., *President's Representative* ..... Elizabeth

Selective Service System, New Jersey Chairman of Advisory Committee to

(Nomination for appointment by National Advisory Committee requested by committee — 11/19/61)
Jesse McCall, M.D. ..... Newton

Statutes Related to the Practice of Medicine and Surgery in New Jersey, Committee to Review

(Established by MSNJ to implement substitute resolutions 7 & 8, 1967 House)
Nicholas A. Bertha, M.D., *Chairman* .... Wharton
Thomas C. DeCecio, M.D. ..... Cliffside Park
Samuel J. Lloyd, M.D. ..... Trenton
Mr. Richard I. Nevin, *Executive Director* .. Trenton
Mr. E. Powers Mincher, *Legal Counsel* ... Pennington
Mr. Vincent A. Maressa, *Executive Assistant* Trenton

Tuberculosis Council, New Jersey State

(Appointment of representative to council requested by Commissioner of Health — 2/19/61)
Rudolph G. Matflerd, M.D. ..... New Brunswick

Welfare Council, New Jersey

(Representative to plan meetings for annual conference on social welfare requested by council — 5/13/66)
John J. Bedrick, M.D. ..... Bayonne

Widows and Orphans of Medical Men of New Jersey, Society for Relief of

(Liaison requested by Society — 5/17/59)
Joseph R. Jehl, M.D. ..... Clifton



News From NJCMD

By now it is impossible for anyone to be unaware of the critical shortage of physicians and other health personnel. This is not yet a "crisis" situation when viewing national averages, although it may soon reach that point. It is a very real and serious problem in certain parts of the country; the two extremes of the demographic population "outside" the suburban areas—namely rural areas and core-city populations.

The latter is demonstrated agonizingly in the ghetto areas of Newark, where a population beset with the worst ills and highest-level need for medical care struggles without even the rudiments of health treatment. The city ranks fifth in the country in unemployment, second in infant mortality and birth rate, seventh in drug addiction and venereal disease, sixth in air pollution, and eighth in heroin addicts. It had 4,000 lead-poisoning cases.

Needless to say, a tremendous burden is placed on the few physicians who have remained in the Newark area, where the doctor and dentist drain is severe. For the forseeable future, one cannot expect physicians to leave their more comfortable practices in the suburbs to set up practice in a core-city. It is probably hopeless to expect bright young minority physicians or new medical graduates to flock to the area to set up private practices. The myriad problems besetting such an attempt are discouraging, if not prohibitive.

Your college, in cooperation with the federal Office of Economic Opportunity, is establishing a pilot program to fill this tragic gap. It is known as the Family Health Care Unit. Now beginning on a test basis, it will be operating in new facilities adjacent to the Martland Hospital at the NJCMD campus in the central ward of Newark. Here, a conscientious commitment is being made to 1,000 families from the demonstration area to oversee their complete health needs. With this relatively small group of neighborhood residents, a program is developing to provide comprehensive, dignified, family-based care with a coordinated team of health specialists.

Other attempts across the country to provide such care programs have often bogged down because the care centers—usually ghetto storefront operations—could not obtain the vital hospital affiliations necessary to back up their promises. The NJCMD program in Newark has its principal effort based at the hospital operation. If this pilot program works and the new test situation is expanded, the whole concept of hospital out-patient care may be in for massive overhaul.

In typical hospital situations, especially in poverty pockets, the patient is degraded and not treated as a person with dignity. Patients simply will not avail themselves of care they so desperately need if they cannot maintain self-respect while receiving that care. If they feel that they are poorly treated or that they are humiliated before the health personnel, they will not accept the treatment, probably will not respond to it, and will not return. Today, clinics are organized toward disease or medical problem category recognition and they do not view the patient as a whole, functioning person. Thus, the orthopedist may view the patient with a fracture as a bone; the eye and ear man sees a sinus, and so on. The patient must be viewed in terms not only of his over-all being and the possibility of other medical problems (which are usually present, and often treatable if discov-

ered promptly); but also in terms of his over-all personal, emotional, physical, social, financial, and psychological environment. These patients are often caught in the unending cycle of social, medical, fiscal, and psychological problems leading to more problems. It's not enough to treat a particular problem or symptom, something with little real bearing on the over-all patient. Thus, the patient is so wrapped up in the day-in, day-out, frightening, and defeating struggle simply to exist, that he is unable to pull himself out of the cycle, and thus return to general good health and something even approaching a happy and useful life. Because her children are unwell, the poor mother is in a constantly agitated state; she probably is not healthy to start with, and this is compounded by her emotional condition and constant fear and worry. She might like to work to help provide for the children and to improve their lot. If they are unwell she cannot leave them to do so. Because they cannot make ends meet, she cannot get the health care necessary to improve their medical problems. The father cannot hold a job because his health is poor; perhaps he cannot keep one because of frequent absences to care for a family when his wife is ill; he may have social and employment problems due to poor teeth and cosmetic difficulties. Or, he may have just given in and resorted to various forms of supposed escape which themselves bring on more problems: drugs, for example.

The introduction and maintenance of good health into this cycle is a major step to rehabilitation for individuals and the entire neighborhood. Thus, the Family Health Care Unit at Martland will approach the problem with this background in mind. The patient, who may be referred from the hospital emergency room which has treated a specific problem, from community social agencies, or from neighbors who know of the Family Care plan, comes to the Center. He is assigned to a specific health team, which may include any number of health specialists to assess and work with his health problems. Thus, the team includes the full gamut of medical specialty interests, a dental health worker, social worker, and so on. The membership of this team hopefully will remain as stable as possible with changes due not to rotation but to a member leaving, transferring, or retiring. The goal here is that while the patient's "family physician" is the health team, the team is specific people he can come to know, trust, and have faith in. And the team is a true "family physician," because patients are treated as family units. One cannot effectively understand—let alone treat—the difficulties of one member of a family unit without knowing what other problems that unit faces. The entire family is seen, given a thorough examination and workup (with regular physical examinations to be continued through the future) and then the members of the family treated not only as individuals, but as members of that functioning unit.

A program in educating the children of these families in good, sound health practices will be maintained, thus building the framework for succeeding generations to improve their basic health through good practices as well as improved care facilities.

The benefits to the physician who is part of the program are obvious. It is hoped that recruiting of qualified health professionals for the area will be improved through the creation of this professional, working health team concept.

For the physician, working in these conditions provides a realistic opportunity for him to practice in an area desperately in need of improved medical care and to provide a meaningful, direct, and readily identified contribution to that end. For his personal situation, this leads to regular hours, a professional earnings' picture, and professional satisfaction without the struggles confronting private practice, especially one in such a difficult area.

The program in many ways offers the advantages of a group private practice, but with the enormous professional and medical benefits of hospital and medical school affiliation.

It is hoped that the program will build the feeling in patients that they want to be in the system *before* trouble arises, so they know what to do and are known should an emergency arise. We all know that anyone rushing into any hospital emergency room feels lost, unknown, and apprehensive. Add to this the resentment and fear of a core-city resident in the face of the system and you can understand what it will mean to him to be known, with his friends as part of the system which is available to treat him. Plus there are the obvious advantages to the health team in having complete medical information on the patient.

One spinoff of the Family Health Care Unit is the ability to provide employment in the program for central ward people. The N.I.H. is funding a New Careers Program under which 60 people from the demonstration area are to be trained in health careers and supporting roles, with a training budget of $3,000 per person.

All of these are demonstration projects. The pilot programs will allow for testing, changing, proving, and records-keeping with full coordination by the Medical College. We hope to build additional facilities, with similar health care delivery programs associated with all the Newark Hospitals.

For further information on this developing program of your medical college hospital complex, write Lee R. Munsick, Director of Professional Relations, NJCMD, 100 Bergen Street, Newark 07103.

ANNOUNCEMENTS

Computers, Cardiology, and Compassion

On September 18 and 19, 1970 at the Holiday Inn in Trenton (West State Street at Calhoun), a colloquium will be held on medicine's meeting the challenge of the computer. AAGP will give up to six credits for both days' attendance. Experts will discuss medical and cardiologic diagnosis, facts and fantasies about pre-operative and post-operative care for the heart surgery patient, biological engineering, the role of the nurse in blood gas monitoring, the computer seen as a rival to the nurse, the coordination of cardiac rehabilitation programs, and the use of social service in preventing or handling emotional crises. Hosted by the New Jersey Heart Association, the program is co-sponsored by the New Jersey State Department of Health, the New Jersey State Rehabilitation Commission, the New Jersey Academy of General Practice, the New Jersey Regional Medical Program, and the New Jersey State Nurses' Association. For more details and a complete program, write to the New Jersey Heart Association, 1525 Morris Ave., Union, New Jersey 07083.

Clinical Application of Basic Sciences

The October programs in the Burlington County Memorial Hospital series, "Clinical Application of the Basic Sciences," have been scheduled as follows:

October 1—Disease States Leading to Ventilatory Failure
October 8—Gas Exchange in the Lung and Peripheral Tissues in Disease States
October 15—Control of Respiration and Relationship to Oxygen Therapy
October 22—Artificial Airways, Oxygen Delivery Systems, and Humidification Systems
October 29—Mechanical Ventilation in Respiratory Failure

The meetings are held on Thursdays at 3:30 p.m. in the Common Room of the T. J. Summey Building of the hospital. For further information, please contact the Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Unique Medical History Symposium

On Saturday, October 24, persons interested in our state's medical history will have an opportunity to enjoy the first New Jersey Medical History Symposium. This will be held in the State Museum, Trenton, beginning at ten o'clock. Registration will open an hour before the program, or you may preregister by writing to the New Jersey Medical History Symposium, P.O. Box 324, Lawrenceville, New Jersey 08648.

The keynote address will be delivered by Dr. David Cowen, Department of History, Rutgers University. Guest speaker is Fred B. Rogers, M.D., Associate Professor of Medicine, Temple University.

The Symposium was formed in February (1970) when a cadres of medical historians, acting on a suggestion by Mr. Bernard Bush of the New Jersey Historical Commission, met at Rutgers University. It is in itself an historic event, and represents a pioneer attempt to honor New Jersey physicians who, through two centuries, have helped to mold American medicine. Dr. Samuel Berg of Newark has designed a seal to commemorate the October meeting.

American Board of Family Practice Examination

The American Board of Family Practice announces its *second* examination for certification will be held over the two-day period, February 27 and 28, 1971, in various centers throughout the United States. For application and information concerning eligibility write to Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506. The deadline for receiving completed applications is November 1, 1970.

Symposium on Dyslexia

Starting at 2 p.m. on Wednesday afternoon, November 4, the New Jersey Academy of Ophthalmology and Otolaryngology will hold a seminar on dyslexia at the Robert Treat Hotel, Park Place, Newark. Papers will cover (a) the pediatrician's responsibility in dyslexia, (b) the ophthalmologist's responsibility, (c) the role of the neurologist and psychiatrist, and (d) the position of the educator in handling the dyslectic child. The $15 registration fee includes both a luncheon and a dinner. For more details, write to H. M. Byron, M.D., 220 Engle Street, Englewood, New Jersey 07631.

Ophthalmology Program in Newark

Wednesday morning, November 4, 1970 will be devoted to a four-paper symposium on problems in modern ophthalmology. Sponsoring agencies are the State Commission for the Blind, the United Hospitals (Eye and Ear Infirmary Unit), the New Jersey College of Medicine and Dentistry, and the New Jersey Academy of Ophthalmology and Otolaryngology. The $15 registration fee includes a luncheon, a dinner, and an afternoon seminar on dyslexia. At the morning session papers will be presented on sarcoid uveitis, traumatic eye injuries, photocoagulation, and oblique surgery. For a full program, write to Herve Byron, M.D., 220 Engle Street, Englewood, New Jersey 07631. This symposium will be held at the Robert Treat Hotel in Newark.

Federal Physicians To Meet

The Association of Military Surgeons and Physicians of the Public Health Service and the Veterans Administration will meet in Washington, D.C. from November 29th to December 2nd. The keynote address will be given by Dr. Roger O. Egeberg, Assistant Secretary of the Department of Health, Education, and Welfare. Topics for the scientific program will include management of inflammatory bowel disease, prediction of suicide, intercranial foreign bodies, drug reactions, the management of facial trauma, and many others. For a complete program write to Dr. Walter Welham, Executive Director, Association of Military Surgeons, 8502 Connecticut Avenue, Chevy Chase, Maryland 20015.

LETTER TO THE JOURNAL

What Are Medical Societies For?

Dear Sir:

The conservative individualism of doctors makes a misnomer of "organized" medicine. This conservatism intensifies as we pass from county through state to national levels.

At one time, medical societies were organized to protect the public and the regular practitioner in all professional, legal, ethical, moral, and scientific matters. The economic aspects were muted and politics was never discussed.

The meetings centered around the scientific program, and business came in at the periphery. Now that hospitals, specialty societies, and drug companies have taken over the scientific program in medicine, County Medical Societies meet only to discuss social events, mutual funds, how to invest or spend the surplus in the treasury, schemes for withholding a slice of current income from taxation, and how to set up a retirement program. The speakers are no longer eminent physicians from the Big City but economists, insurance brokers, and stock market analysts. Politics is avoided like a plague for which there is no treatment except isolation. The only politics County Societies are urged to be active in is to support legislators who will fight government influence in medical care. That would not be an ignoble policy if action were also taken in other public affairs. Justice O. W. Holmes, who knew something about action, law, and public affairs, noted that, "Life is action and passion. I think it is required of a man to share the action and passion of his time at peril of being judged not to have lived." That thought is voiced in every critical age as when Pericles called him who holds aloof from public affairs as "useless." Ditto for organizations whose only purpose is self-interest however nobly disguised.

If the County Societies are dead, State Societies are in ICU. Program Chairmen still diligently pursue scientific sessions but interest and attendance continue to dwindle. Twenty-five years ago, the number of members at the Annual Meeting was four-to-five times that of Delegates; now one gets the impression that only those who must be there, attend.

Committees and Delegates meet to discuss public health matters, legislation affecting the economics and practice of medicine, and who will get what from Blue Cross and Blue Shield. Legislators do not seem to have a high regard for the political acumen and motives of the medical profession; they seldom consult us when drafting a bill or voting on a measure. We are always on the defensive in a last-ditch fight to defeat objectionable bills or support acceptable ones.

State medical societies have failed to stem the overwhelming rise in malpractice insurance costs, fraudulent claims, suits, and awards. Committees delegated to solve this problem have been conclaves of mice debating how to bell the cat.

The summit of organized medicine is the AMA, though barely half the M.D.s are members. It performs all the professional services such a body should and does them well except in politics and public relations. The Baxter and Company fiasco did not improve the image of organized medicine or its finances. AMPAC, the AMA's political arm was frankly and enviously modeled after COPE, Labor's Committee on Political Education; but AMPAC has been an amateurish imitation. Its legitimate activities have not impressed the public or the politicians, whereas in at least one disastrous attempt to discredit a Pittsburgh labor leader (through a bogusly recorded speech) the AMA was obliged to admit the libel and pay $400,000 in damages. In reading the minutes of the congressional hearings on Medicare, one winces at the political ineptitude of doctors. The Congressmen were deferential at first but later became impatient with the credibility of the medical witnesses.

And the AMA spent a reputed $14,000,000 in the unsuccessful fight against Medicare, proving (as the federal government has in Viet Nam) that money alone cannot buy victory. No wonder doctors avoid politics.

But that can be a shameful evasion. The doctors in Hitler's Germany remained silent when the ovens and gas chambers were going full blast; they blandly conducted vile experiments—under orders from a better informed and more highly motivated political headquarters.

Bar Associations speak out courageously when extraordinary political situations arise, and they do try to influence the course of national policy. Organized medicine doesn't even admit these extraordinary political issues into discussion. A closer look to see who is doing what for us and to us in the name of democracy is in order.

Never before have such great moral, social, economic and civic problems wracked the nation at home and abroad, and yet the one truly humanitarian profession has remained prudently silent. One reason given is that such controversial discussion would alienate the members, but whenever did doctors agree? They might turn for comfort to page 7 of *Religio Medici* and see what Thomas Browne, M.D. has to prescribe: "I could never divide myself from any man upon the difference of an opinion, or be angry with his judgment for not agreeing with me . . ."

When humanitarianism is lost in science, economics, politics, or personal expediency, we risk contempt from posterity, and the most proximal posterity is the generation judging us now. Individual doctors today—let us mention Spock—have taken a stand against collective hatred, violence and unlawfulness, but it is distressing to hear so little of protest from organized medicine.

Perhaps we don't care what the generation on the firing line says or thinks about us. But this is the one that has been immersed in almost six years of creeping disaster with 42,000 young men killed at a cost of one billion dollars a month while the projected Great Society at home has turned into a snarling shambles. Perhaps we can't learn anything from the younger generation, but we could from an older. In 1775, on the eve of the Revolution, when George the Third chose a military solution for a moral problem, Edmund Burke arose in the House of Commons to speak in favor of "Conciliation with America." When he was reminded that the silent majority was with the Government, he replied: "All that is necessary for evil to triumph, is for good people to remain silent."

Burke did not at first persuade the silent majority to speak out, and it wasn't until 1777 that William Pitt, Prime Minister, spoke out against the evil in the colonies: "If I were an American as I am an Englishman, while a foreign troop was landed in my country I would never lay down my arms — never! never! never!"

The parallel is obvious. Old Kasper in Southey's "After Blenheim," concludes the story of the battle with: "And everybody praised the Duke who this great fight did win." Whereon little Peterkin asks: "But what good came of it at last?" To which Old Kasper replies: "Why that I cannot tell, but 'twas a famous victory."

And that is precisely the question our little Peterkins are asking though our Iron Dukes have still to win this great fight.

Another question asked and answered may be found in Genesis 4:9-11. If the medical profession can't answer this one, who can?

(signed) Nicholas D. Demy, M.D.

Editor's Note: Actually, the medical societies did not start as scientific bodies. Early meetings (18th century) were essentially "guilds" and fee schedules were common meeting topics in those days. In a sense, Dr. Demy is putting any state medical society in an impossible position. The burgeoning of specialty societies and hospital clinical staff meetings must inevitably reduce interest in the attendance in the scientific programs of state societies. Yet he criticizes these societies for turning to problems in public affairs.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1970

September

16 **New Jersey Heart Association and New Jersey State Dental Society**
Brunswick Inn, New Brunswick
Symposium for Dentists

16 **St. Barnabas Medical Center**
Department of Obstetrics and Gynecology
Livingston
Pathology Course in Obstetrics and Gynecology

17 **Burlington County Memorial Hospital**
Mount Holly
Future Patterns of Medical Care

17 **Morris County Medical Society**

17 **Gloucester County Medical Society**

17 **Academy of Medicine of New Jersey**
Columbia College of Physicians and Surgeons, New York
Acute Respiratory Insufficiency Management

18 and 19 **New Jersey Heart Association**
Holiday Inn, Trenton
Medicine and the Computer

20 **New Jersey State Dental Society**
Section on Dermatology
Nassau Inn, Princeton

23 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Pulmonary Function Tests

23 **St. Barnabas Medical Center**
Department of Obstetrics and Gynecology
Livingston
Pathology Course in Obstetrics and Gynecology

24 **Burlington County Memorial Hospital**
Mount Holly
Physician's and Patient's Attitude Toward Illness

27 **Cape May, Cumberland, Gloucester, and Salem County Medical Societies**
Vineland, New Jersey
Symposium

28 **Cape May County Medical Society**

30 **Academy of Medicine of New Jersey**
Newark Beth Israel Medical Center
Bedside Treatment of Shock

30 **St. Barnabas Medical Center**
Department of Obstetrics and Gynecology
Livingston
Pathology Course in Obstetrics and Gynecology

October

3-4 **New Jersey Heart Association**
Holiday Inn, Atlantic City
Coronary Care in the 1970s

5-9 **Academy of Medicine of New Jersey**
Beth Israel Medical Center, Newark
Vectorelectrocardiography

6 **Hudson County Medical Society**

7 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Hematology

7 **St. Barnabas Medical Center**
Department of Obstetrics and Gynecology
Livingston
Pathology Course in Obstetrics and Gynecology

7 **Academy of Medicine of New Jersey**
Academy of Medicine Offices
Bloomfield, New Jersey
Round Table on Internal Medicine

9 **Academy of Medicine of New Jersey**
Saint Barnabas Medical Center
Livingston
Ventilatory Management of Infants and Children

14 **Middlesex County Medical Society**

14 **TB-Respiratory Disease Association of Southern New Jersey**

14 **Ocean County Medical Society**

14 **Bergen County Medical Society**

14 **Cumberland County Medical Society**

14 **St. Barnabas Medical Center**
Department of Obstetrics and Gynecology
Livingston
Pathology Course in Obstetrics and Gynecology

14 and 21 **Academy of Medicine of New Jersey**
Neurological Institute of Health
New York City
Neurology

14 **Academy of Medicine of New Jersey**
Saint Michael's Hospital, Newark
Pulmonary Disease

15 **Morris County Medical Society**

15 **Gloucester County Medical Society**

16 **Academy of Medicine of New Jersey**
Mount Sinai Hospital, New York
Sarcodosis

21 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Pleural Effusion

21 **St. Barnabas Medical Center**
Department of Obstetrics and Gynecology
Livingston
Pathology Course in Obstetrics and Gynecology

21 **New Jersey State Diabetes Association**

28 **St. Michael's Medical Center**
Newark
Asthma and Allergic Disease of the Lungs

28 **St. Barnabas Medical Center**
Department of Obstetrics and Gynecology
Livingston
Pathology Course in Obstetrics and Gynecology

28 **Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Esophageal Disease

November

3 **Hudson County Medical Society**

4 **Academy of Medicine of New Jersey**
St. Vincent's Medical Center
New York City
Isotope Scanning of Lung, Liver, and Spleen

4, 11 and 18 **Academy of Medicine of New Jersey**
Mountainside Hospital
Montclair
Esophageal Disease

10 **Bergen County Medical Society**

11 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Infectious Disease

11 **TB-Respiratory Disease Association of Southern New Jersey**

11 **Ocean County Medical Society**

11 **Middlesex County Medical Society**

12 **Academy of Medical of New Jersey**
St. Michael's Medical Center
Newark
Renal Disease

18 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Fever of Unknown Origin

19 **Morris County Medical Society**

19 **Gloucester County Medical Society**

30 **Cape May County Medical Society**

December

2 and 9 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Uremia

2 **Hudson County Medical Society**

3-4 **Academy of Medicine of New Jersey**
Saint Barnabas Medical Center, Livingston
Culdoscopy Workshop

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

8 **TB-Respiratory Disease Association of Southern New Jersey**

8 **Ocean County Medical Society**

8 **Middlesex County Medical Society**

16 **Academy of Medicine of New Jersey**
Mount Sinai School of Medicine
New York
Hematology

16 **Academy of Medicine of New Jersey**
Cornell Medical Center, New York
Transplantation

17 **Morris County Medical Society**

1971

January

5 Hudson County Medical Society

6 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Cardiology

10 TB-Respiratory Disease Association of Southern New Jersey

10 Ocean County Medical Society

10 Middlesex County Medical Society

12 Bergen County Medical Society

13 Academy of Medicine of New Jersey
St. Michael's Medical Center
Newark
Cardiology

16 Warren County Medical Society

18 Gloucester County Medical Society

20 and 27 Academy of Medicine of New Jersey
St. Michael's Medical Center
Newark
Cardiology

February

2 Hudson County Medical Society

3 Academy of Medicine of New Jersey
St. Michael's Medical Center
Newark
Cardiology

4 Saint Barnabas Medical Center,
Livingston
Hormonal Cytology

3 and 10 Academy of Medicine of New Jersey
Saint Michael's Medical Center,
Newark
Cineangiography

10 and 17 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Cardiology

24 Academy of Medicine of New Jersey
Albert Einstein Medical Center,
Newark
Pediatric Renal Disease

24 Academy of Medicine of New Jersey
St. Michael's Medical Center
Newark
Cardiology

March

2 Hudson County Medical Society

2 Academy of Medicine of New Jersey
Academy of Medicine Offices,
Bloomfield
Section on Dentistry

4 Academy of Medicine of New Jersey
National Institutes of Health
Bethesda, Maryland
Clinical Infectious Diseases

4 Saint Barnabas Medical Center
Livingston
Multiparous Trap

9 Bergen County Medical Center

9 TB-Respiratory Disease Association of Southern New Jersey

9 Middlesex County Medical Society

10 Academy of Medicine of New Jersey
Overlook Hospital, Summit
Respiratory Failure

17 Academy of Medicine of New Jersey
Cornell School of Medicine, New York
Cardiac Drugs

18 Morris County Medical Society

18 Gloucester County Medical Society

24 Academy of Medicine of New Jersey
Dental Section
Symposium

24 Academy of Medicine of New Jersey
Massachusetts General Hospital, Boston
Gastrointestinal Disease

29 Cape May County Society

31 Academy of Medicine of New Jersey
Cornell Medical Center, New York
Heart Surgery

31 Academy of Medicine of New Jersey
Symposium—Controversy in Medicine

April

6 Hudson County Medical Society

7 and 14 Academy of Medicine of New Jersey
Holy Name Hospital, Teaneck
Uremia

OBITUARIES

Dr. Samuel R. Deich

A past-president of the American Academy of General Practice and a pioneer in efforts to upgrade the status and dignity of the family physician, Samuel R. Deich, M.D., died on July 16, 1970, at the age of 62. He earned his degree at the Jefferson Medical College in 1932 and was affiliated with St. Mary's Hospital in Passaic. Dr. Deich was, for many years, the senior police surgeon for the city of Passaic.

Dr. William J. Fitzhugh

The Ridgefield Park Kiwanis Club honored him recently as the "Man of the Year." Indeed, he had been police surgeon, fire department physician, school doctor, Board of Health adviser, and almost everything in medicine in this part of Bergen County. Born in Virginia in 1903, Dr. William J. Fitzhugh won his M.D. at the University there in 1928. In 1930 he came to Bergen County, originally as a plant physician for an Edgewater company. But he soon made himself felt in all aspects of civic and professional life in the Ridgefield Park area. He was a family doctor and exemplified all the qualities of general practice, And, at his death, on July 18, 1970, all flags in Ridgefield Park were lowered to half-mast.

Dr. Paul F. Hennig

Born in Germany in 1890, Dr. Paul F. Hennig came to the United States in 1920. He attended the College of Medical Evangelists in Los Angeles, being graduated from that school in 1933. He then came to Irvington, New Jersey, and served the people of that Essex County town for many years. Dr. Hennig did graduate work in radiology and roentgenology, earning a board diploma in that specialty. In 1964, he retired to his native country and died there on March 26, 1970.

Dr. Paul R. Kline

One our state's senior dermatologists, Paul R. Kline, M.D., died on July 11, 1970. He was board certified in syphilology and dermatology, on the faculty of New York University's Bellevue Hospital in the rank of associate professor, and was senior attending dermatologist at the Helene Fuld Hospital in Trenton. Dr. Kline received his medical degree at the New York Medical College in 1930. In World War II, he served on active duty as a Lieutenant Commander in the Navy. He was 63 years old at the time of his death.

Dr. Joseph Pantaleone

The founder of the Trenton Philosophical Society, Joseph Pantaleone, M.D., died on July 16, 1970 at the age of 69. A member of our Mercer County component, he was a general practitioner with a broad range of interest in many aspects of history, science, and theology. His M.D. came from the medical school of Boston University, 1928. He was on the staff of the St. Francis Hospital in Trenton.

Dr. Attilio Rizzolo

One of the few New Jersey physicians possessed of a "bachelor of humanities" degree, Attilio Rizzolo, M.D., died on June 3, 1970, at the age of 71. For many years he was an examiner for the U.S. Civil Service Commission. He was an early worker in the field of neurophysiology and did original work on chronaxie. His interest in neurophysiology led him into the field of psychiatry and he maintained a psychiatric orientation in his family practice. A graduate of the medical school at the University of Rome, he received his M.D. there in 1934. Dr. Rizzolo practiced in Verona, New Jersey.



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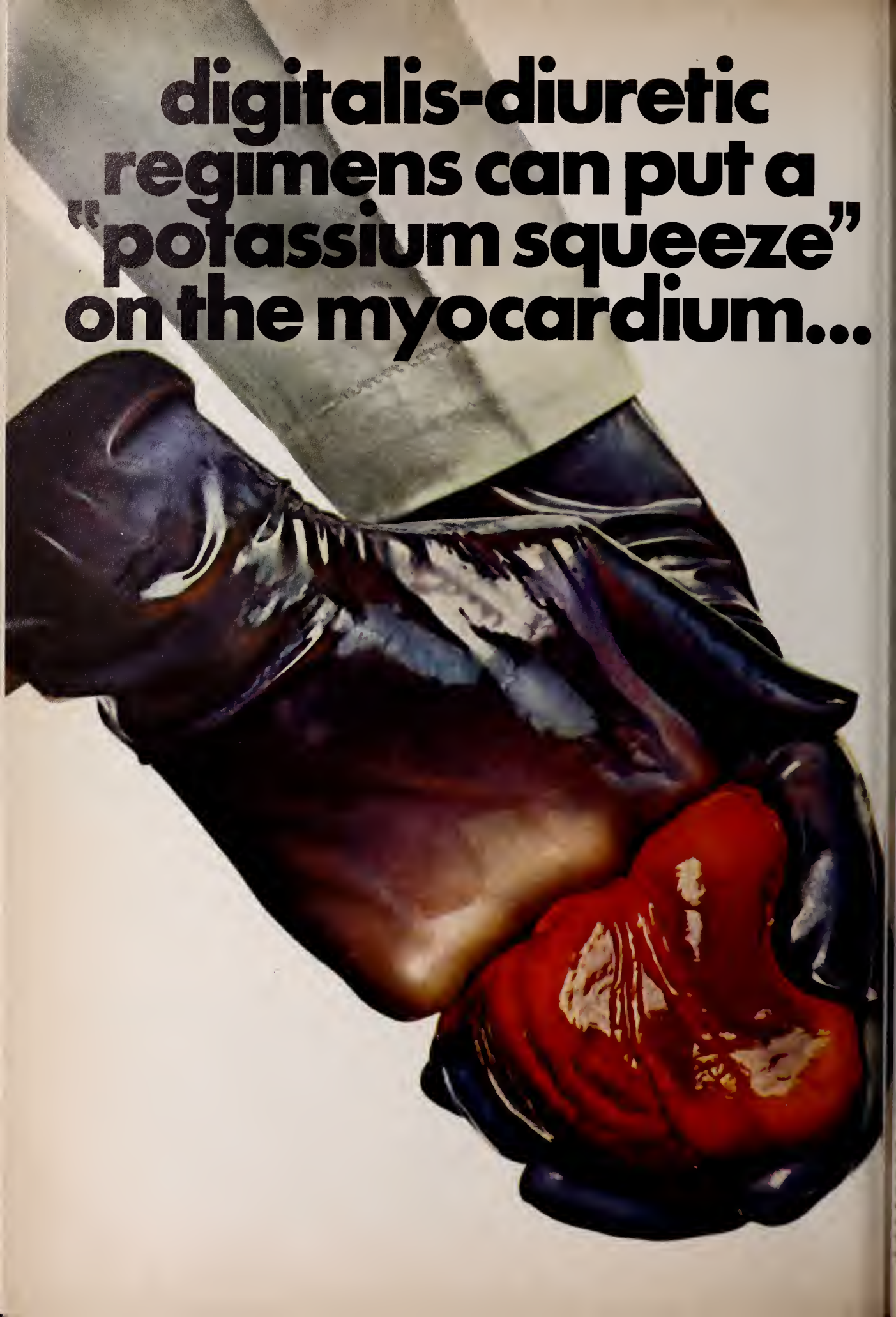
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Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone, particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops.

Usoge of ony drug in women of childbeoring age requires thot the potentiol benefits of the drug be weighed ogoinst its possible hozords to the mother ond fetus.

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 per cent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For *essential hypertension in adults* the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dasage according to response of patient.

For *edema, oscites or effusions in adults* initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For *children* the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: **1.** Dall, J. L. C.: Amer. Heart J. 70:572-574 (Oct.) 1965. **2.** Liddle, G. W.: Ann. New York Acad. Sci. 139:466-470 (Nov.) 1966. **3.** Gantt, C. L.: Diuretic Therapy, DM (Disease-A-Month), Chicago, Year Book Medical Publishers, Inc., 1967, pp. 1-31. **4.** Alexander, S.: Geriatrics 23:131-139 (Nov.) 1968. **5.** Stason, W. B., and others: Circulation 34:910-920 (Nov.) 1966. **6.** Lieberman, F. L., and Reynolds, T. B.: Gastroenterology 49:531-538 (Nov.) 1965.

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Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

Warning: Do not exceed recommended dosages.

Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Adverse Reactions: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

Dosage and Administration: Adults: Two tablets, orally, four times per day, followed by liberal fluid intake. Older children reduce dosage in proportion to age and weight.

How Supplied: Bottles of 50, 500 and 1,000 tablets.

References: (1) Sand, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961: (3) Haas, J., and Kay, L.L.: Southwest. Med. 42:30-32, 1961:(4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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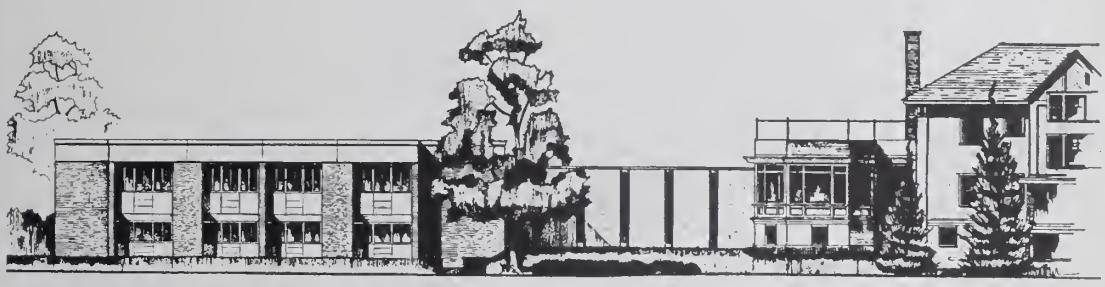
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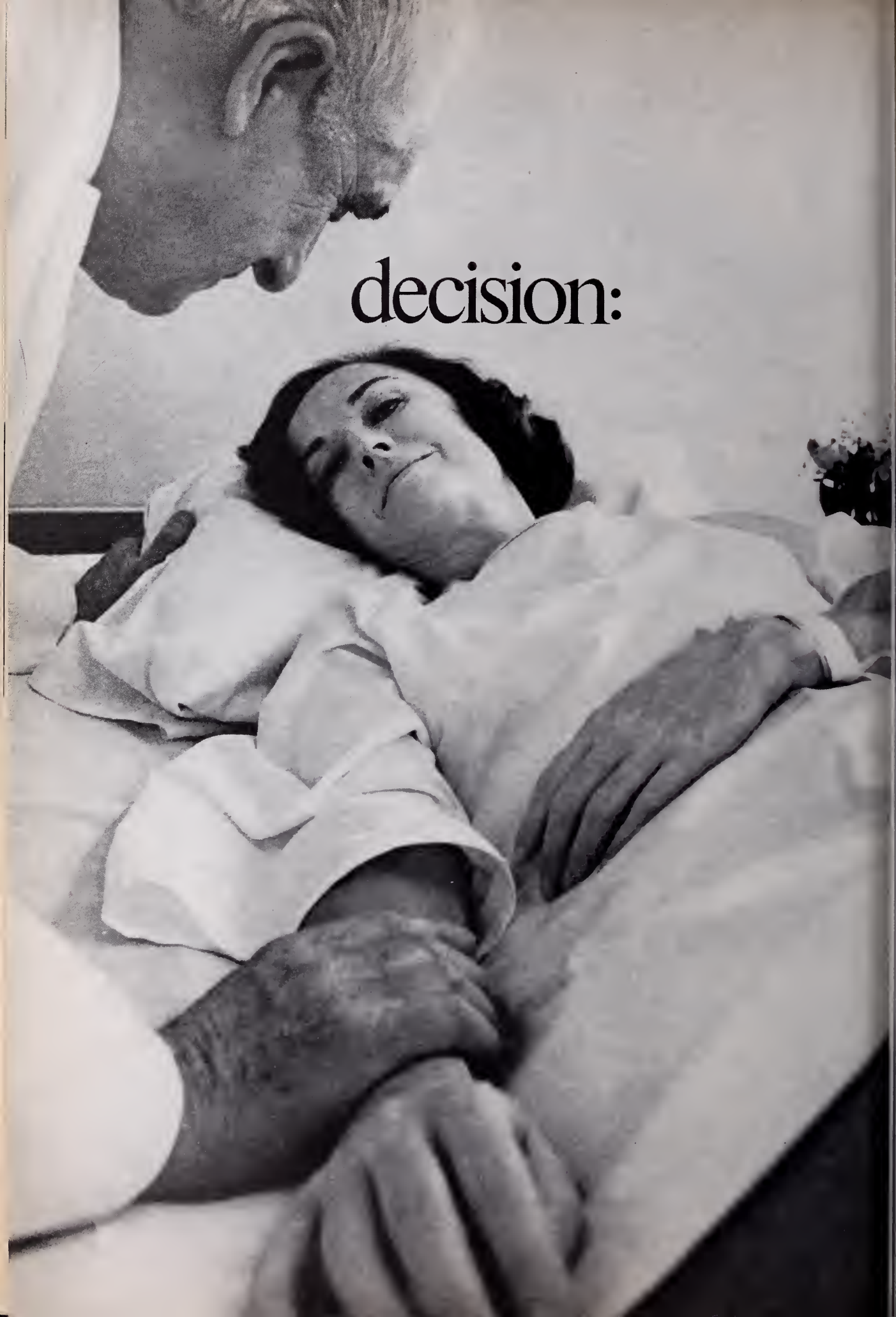
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decision:

Loridine® I.M.
Cephaloridine

1.5 to 3 Gm. daily successfully treats many moderately severe infections*

- bactericidal action in vitro against susceptible organisms causing:
  pneumonia
  urinary tract infections
  septicemia
  abscesses
- broad-spectrum activity
- relatively painless I.M. injection

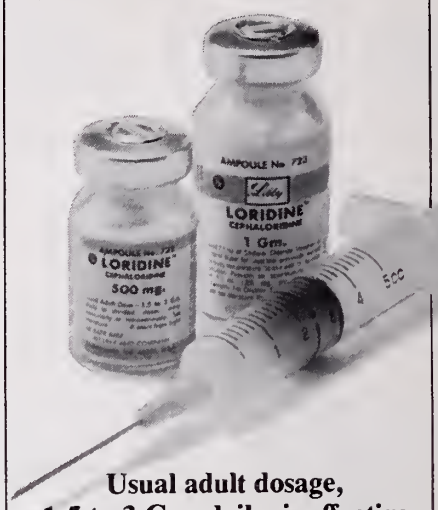
*due to susceptible organisms

Special Recommendations
Before Administration of Loridine
1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.
During Administration of Loridine
1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

Lilly Loridine® CEPHALORIDINE

Please turn page for prescribing information.

Loridine®
CEPHALORIDINE



Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

Additional information available upon request.

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Sandoz announces...

a new agent for the alcohol-dependent patient who wants to quit

and

a program for the New Jersey physician who wants to help



When alcohol becomes a way of life



new SERENTIL® (mesoridazine)

a major tranquilizer with specific advantages for the alcohol-dependent patient:

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
3. Antiemetic properties to control nausea and vomiting.
4. Has not caused hepatic dysfunction or interfered with functional recovery of impaired liver.
5. Four tablet strengths to allow flexibility of dosage (usual starting dose: for the problem drinker, 10 mg. t.i.d.; for the frank alcoholic, 25 mg. b.i.d.).
6. Injectable form available for acute episodes.



a program for early recognition and successful treatment:

Alcoholism in New Jersey*

	State Rank
total no. alcoholics	7th
no. per capita	10th
per capita consumption†	11th

New Jersey Physicians' Report
(compared with U.S. average)

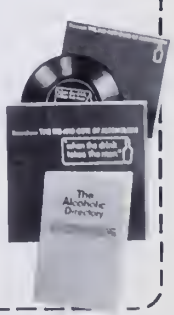
	%N.J.	%U.S.
see 5 or more problem drinkers in 2-month period	34.7	37.1
half or more seen are women	41.8	37.4
treat, rather than refer	73.1	72.6
more community services needed	65.0	63.0

*based on preliminary data supplied by Center of Alcohol Studies, Rutgers Univ. †absolute alcohol

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory,** a nationwide survey of treatment centers.

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See next page for prescribing information.

INDICATIONS: In clinical studies, Serentil (mesoridazine) has been found useful in the following disease states:

Alcoholism—Acute and Chronic: Serentil ameliorates anxiety, tension, depression, nausea and vomiting in both acute and chronic alcoholics without producing hepatic dysfunction or hindering the functional recovery of the impaired liver.

Schizophrenia: Serentil is effective in the treatment of schizophrenia. It substantially reduces the severity of Emotional Withdrawal, Conceptual Disorganization, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychaneurotic Manifestations: Serentil reduces the symptoms of anxiety and tension, prevalent symptoms often associated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

Attention should be paid to the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related to Serentil, one should be aware that such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection.

Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of a few

SERENTIL®
(mesoridazine)
new weapon in the fight against alcoholism

(rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found among those patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos) have been reported.

Autonomic Nervous System: Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiovascular System: Hypotension and tachycardia have been reported. EKG changes have occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the following have occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autonomic Reactions: Miosis, obstipation, anorexia, paralytic ileus.

Cutaneous Reactions: Erythema, exfoliative dermatitis, contact dermatitis.

Blood Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edema, asthma.

Hepatotoxicity: Jaundice, biliary stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed in some patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarization and not related to myocardial damage. They appear to be reversible. There is no evidence at present that these chong are in any way precursors of ony significant d turbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arre has been noted.

Extrapyramidal Symptoms: Akathisia, agitati motor restlessness, dystonic reactions, trism torticollis, opisthotonos, oculogyric crises, trem muscular rigidity, akinesia—some of which rare occasions have persisted for several mont or years especially in patients of advanced o with brain damage.

Endocrine Disturbances: Menstrual irregulariti altered libido, gynecomastia, weight gain. Fal positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects sugg tive of a paradoxical reaction have been reporte These include excitement, bizarre dreams, agg vation of psychoses and toxic confusional stat More recently, a peculiar skin-eye syndrome h been recognized as a side effect following lon term treatment with phenothiazines. This reactic is marked by progressive pigmentation of arec of the skin or conjunctiva and/or accompanied b discoloration of the exposed sclera and corne Opacities of the anterior lens and cornea d scribed as irregular or stellate in shape hav also been reported.

DOSAGE AND ADMINISTRATION: Oral: The do age of Serentil (mesoridazine), as in most me cations, should be adjusted to the needs of th individual. The lowest effective dosage shoul always be used. When maximum response achieved, dosage may be reduced gradually t a maintenance level.

Alcoholism: For most patients the usual startin dose is 25 mg. b.i.d. The usual optimum tot daily dose range is 50-200 mg. per day.

Schizophrenia: For most patients, regardless d severity, a starting dose of 50 mg. t.i.d. is reco mended. The usual optimum total daily dose rang is 100-400 mg. per day.

Behavioral Problems in Mental Deficiency an Chronic Brain Syndrome: For most patients a sta ing dose of 25 mg. t.i.d. is recommended. Th usual optimum total daily dose range is 75-300 m per day.

Psychoneurotic Manifestations: For most patients th usual starting dose is 10 mg. t.i.d. The usual op mum total daily dose range is 30-150 mg. per da

Injectable Form: In those situations in which a intramuscular form of medication is indicate Serentil (mesoridazine) Injectable is available. Fo most patients a starting dose of 25 mg. is reco mended. The dose may be repeated in 30 to 6 minutes, if necessary. The usual optimum total dail dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 mg and 100 mg. mesoridazine (as the besylate). Bo tles of 100.

Ampuls: 1 cc. [25 mg. mesoridazine (as the besy ate)]. Inactive Ingredients—Disodium Edetate U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 mg. Carbon Dioxide Gas (Bone Dry), q.s.; Water for Injection, U.S.P., q.s. to 1 cc. Boxes of 20 and 100

SER70-101

Sandoz Pharmaceuticals, Hanover, N.J.

I love my family.
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My in-laws are great.
The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition. Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing famil Especially when she's confined to the home a its environs so much.

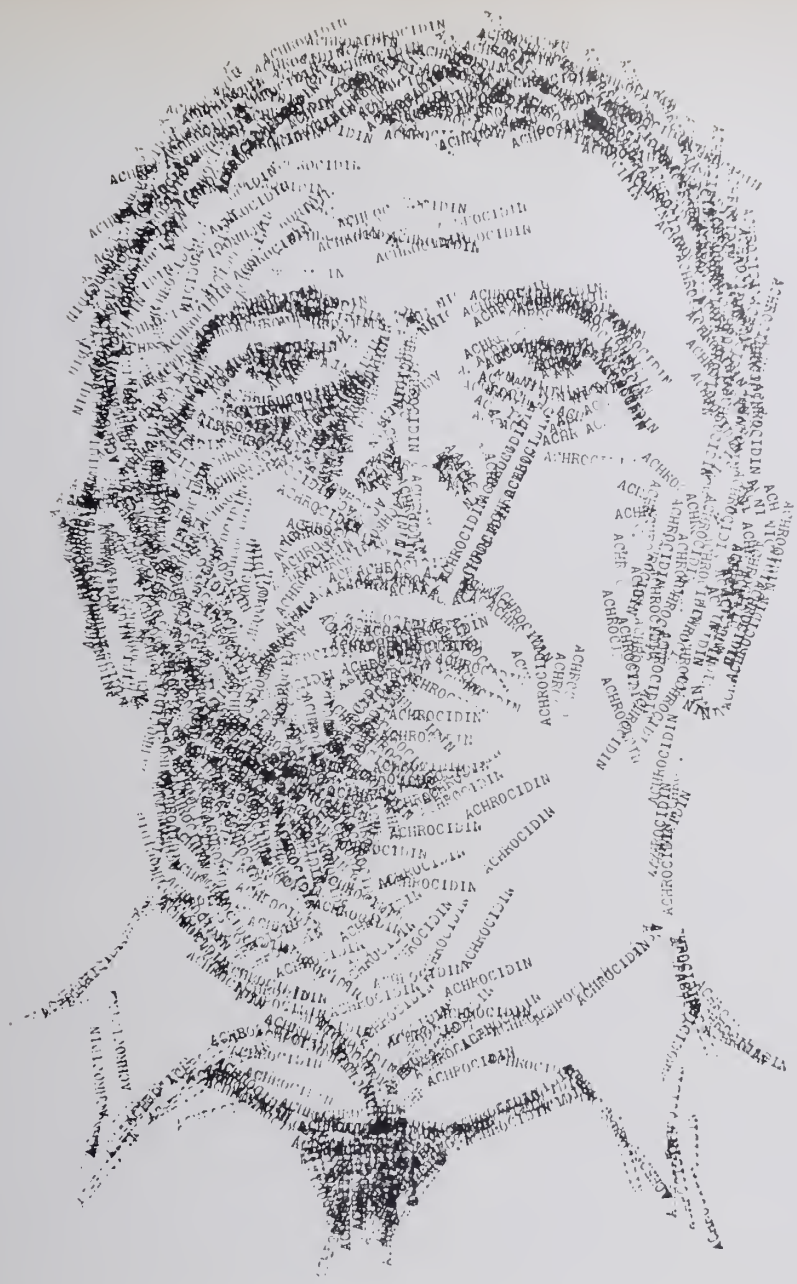
You can help her over the rough spots with reassurance and couns Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probabl do the rest.

Equanil®
(meprobamate

Wyeth Laboratories
Philadelphia, Pa.

Photo professionally posed.

I'll scream if I don't get away!



Achrocidin® Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

ach tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

CHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment f tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the pper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly atients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to etracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

ntraindications: Hypersensitivity to any mponent.

arning: In renal impairment, since liver tox- ty is possible, lower doses are indicated; dur- g prolonged therapy consider serum level terminations. Photodynamic reaction to sun- ht may occur in hypersensitive persons. otosensitive individuals should avoid expo- re; discontinue treatment if skin discomfort curs.

ecautions: Drowsiness, anorexia, slight gas- c distress can occur. In excessive drowsi- s, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

535-9

Personnel Needs See Pages 25A, 26A, 27A



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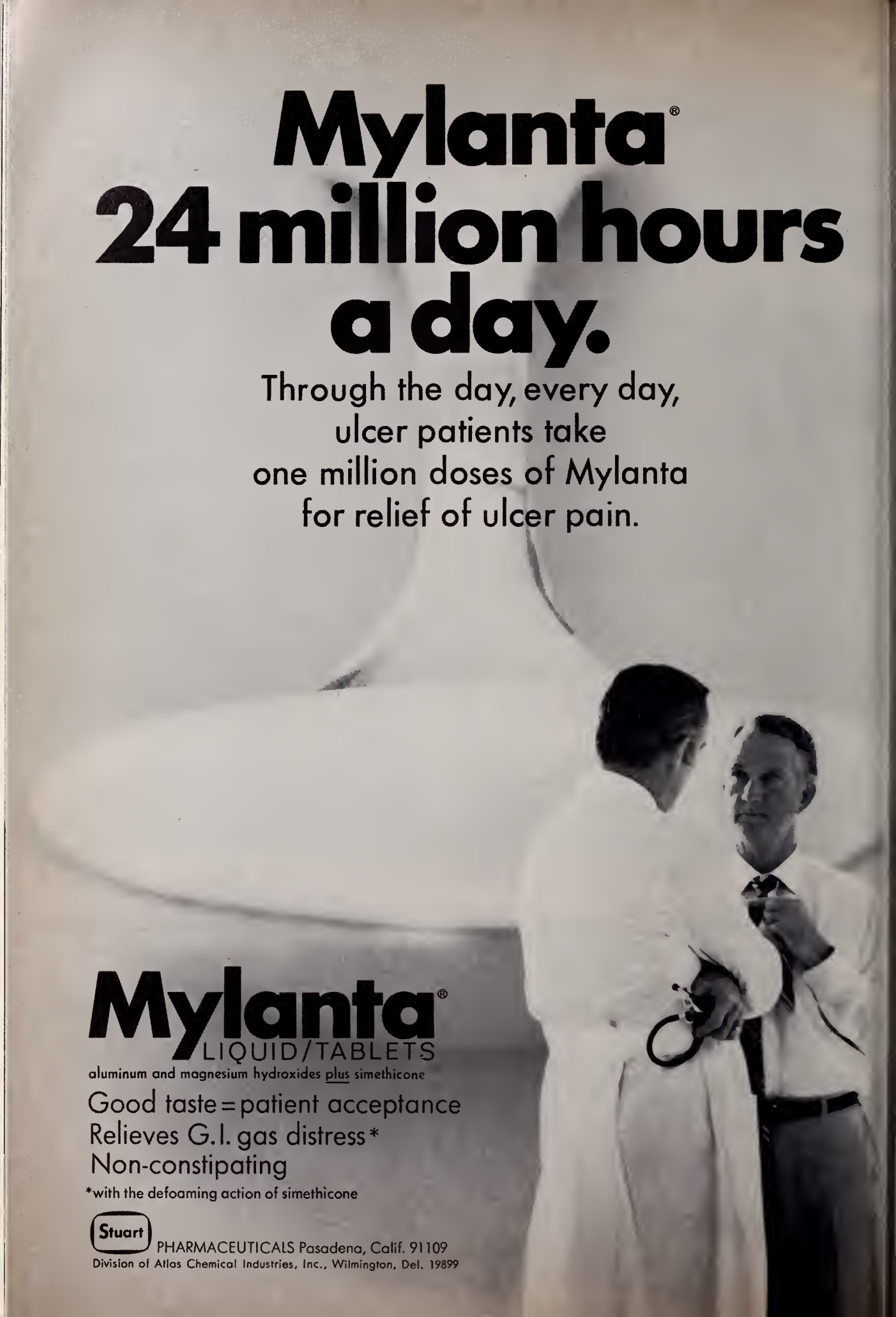
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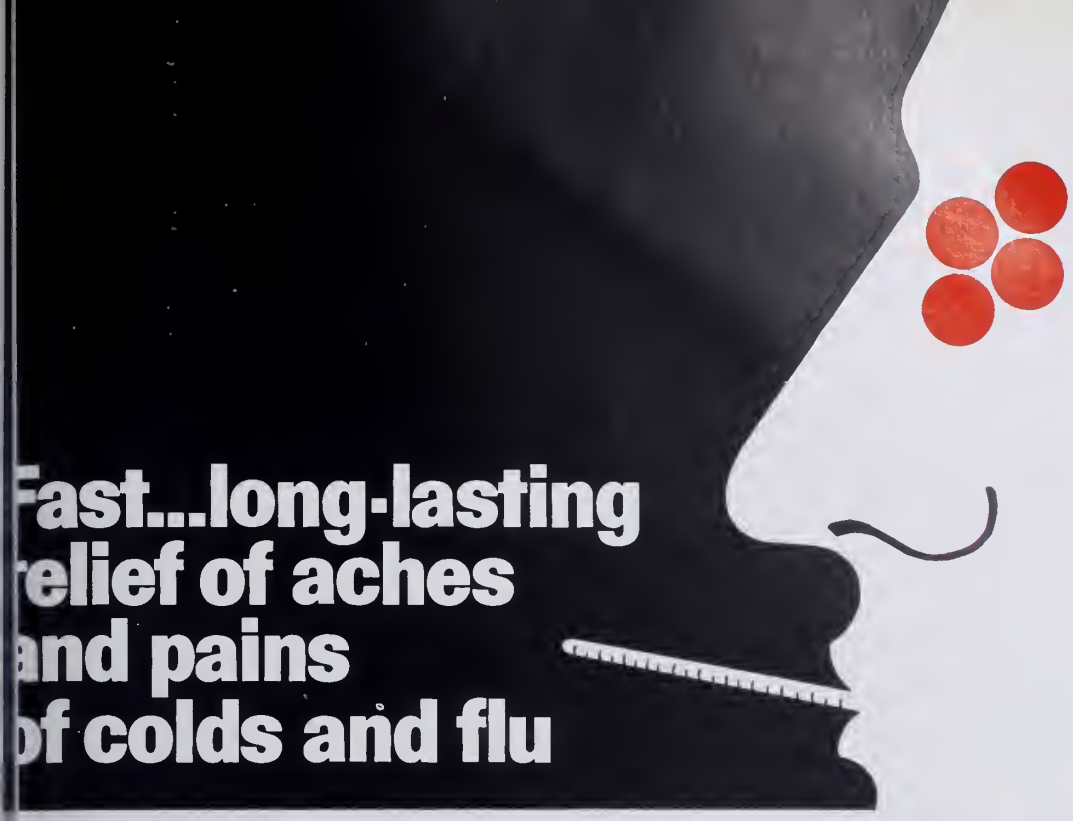
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OF THE MEDICAL SOCIETY OF NEW JERSEY

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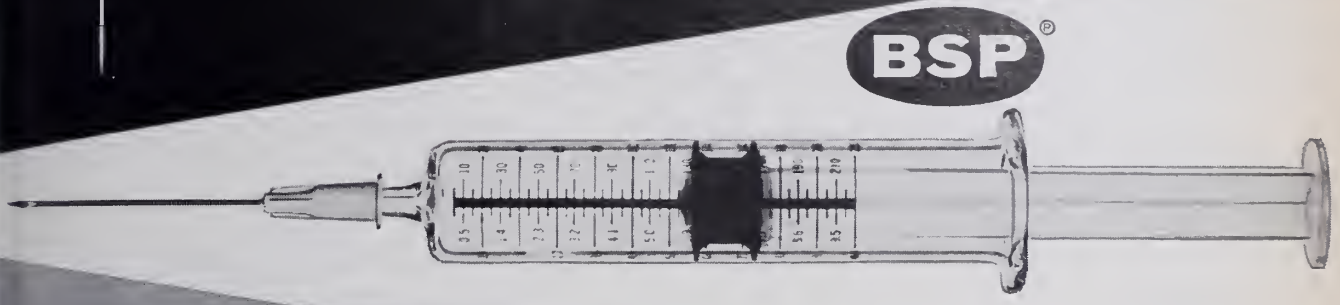
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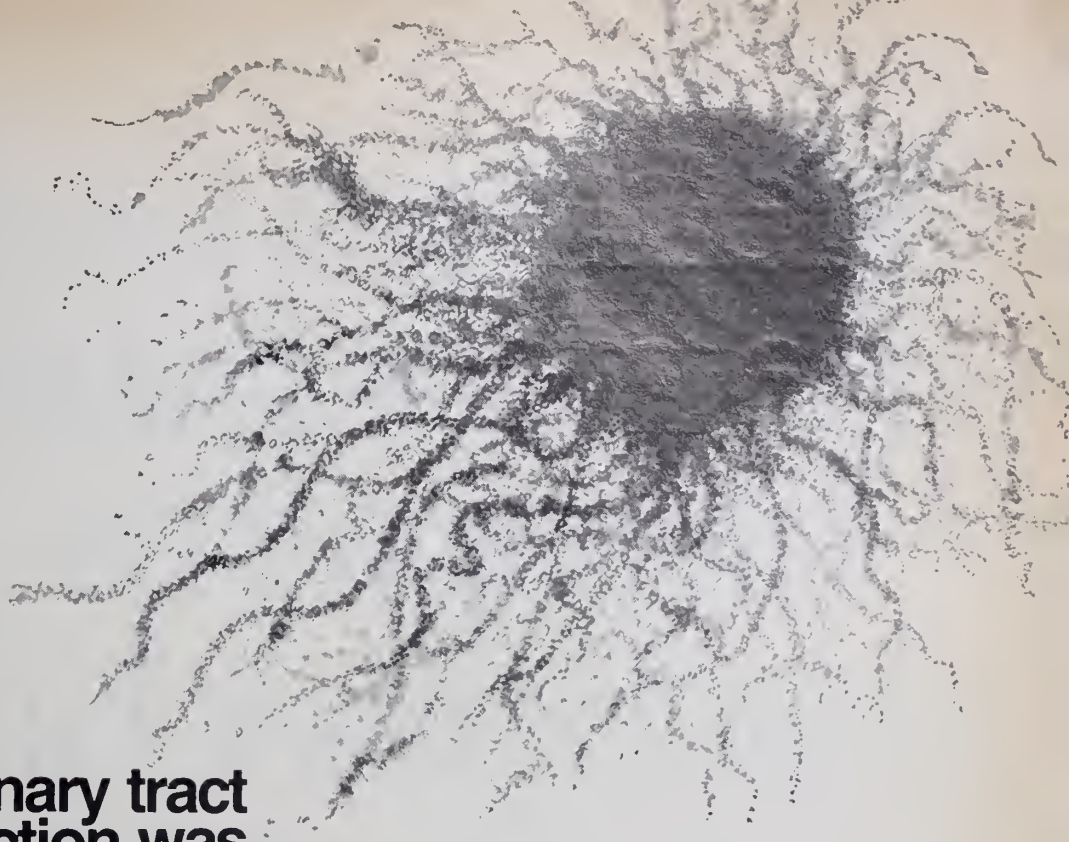
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Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 450-9

Menrium® treats the menopausal symptoms that bother him most.

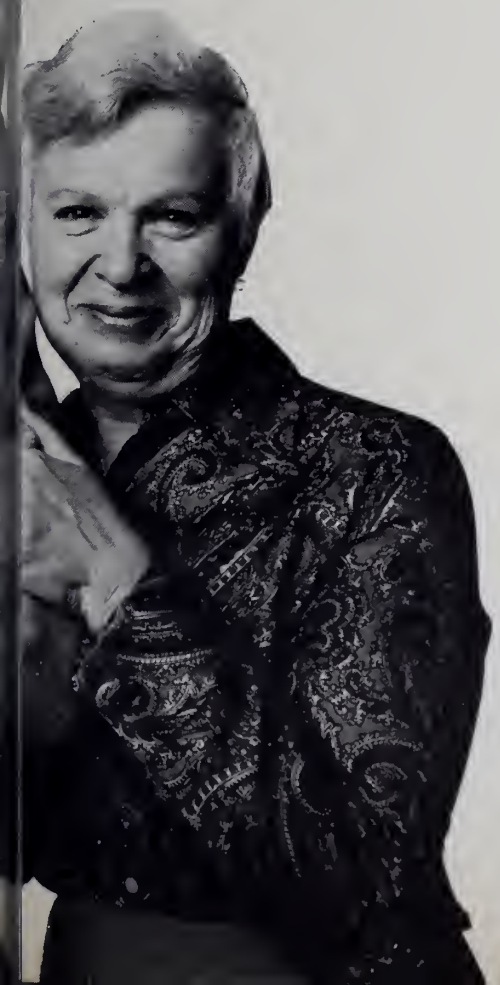


Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through *her* menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

Mead Johnson–pharmaceuticals created for your specialized clinical needs



new 10% solution...
particularly convenient for home use

MUCOMYST®-10
(ACETYLCYSTEINE)

liquefies thick, viscid mucus in chronic bronchitis and emphysema

Mucomyst, as 20% acetylcysteine, has been used with safety and effectiveness in hospitals for over five years.

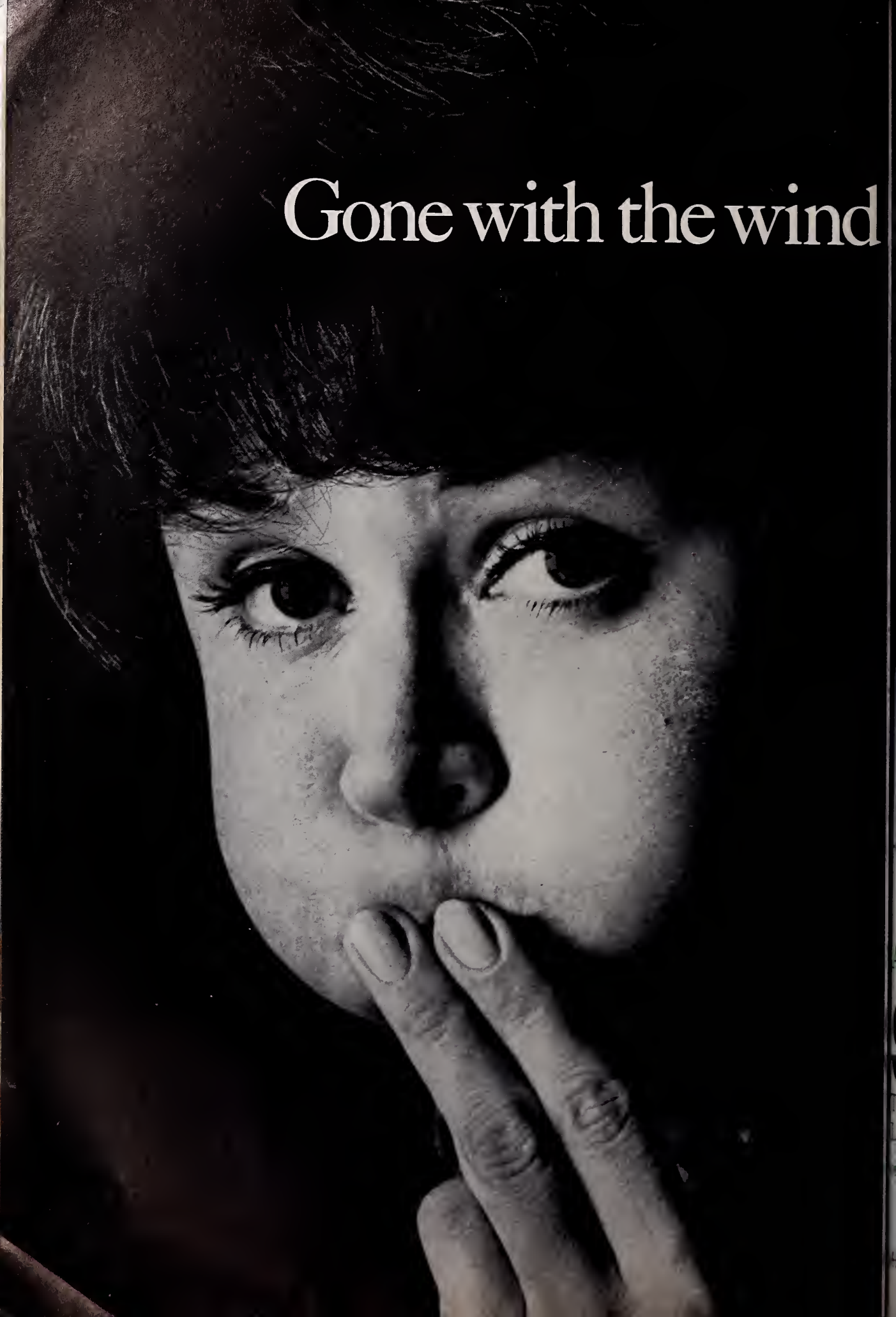
Now a new 10% solution, Mucomyst-10, offers you the choice of prescribing a lesser concentration whenever you feel this is desirable. It provides added convenience and simplicity, particularly for your patients using nebulizing units at home.

By including Mucomyst-10 in the home management regimen, you can provide full mucolytic benefits for many of your patients with chronic bronchitis and emphysema complicated by tenacious secretions.

Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings: After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched carefully. If bronchospasm progresses, this medication should be immediately discontinued. Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied: Mucomyst-10 (acetylcysteine)**, a sterile 10% solution, in vials of 10 ml. and 30 ml.; **Mucomyst (acetylcysteine)**, a sterile 20% solution, in vials of 10 ml. and 30 ml.

Mead Johnson
LABORATORIES

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Gone with the wind

The gas/acid group of disorders

"The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and 'gas.' The two often occur together."*

Frees captured gas...neutralizes free acid

SILAIN-GEL Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

Always in good taste

The pleasant, distinctive flavor of SILAIN-GEL, as well as its non-constipating feature, make it a therapy your patients can live with—in comfort and without complaint.

Select the form of SILAIN-GEL you want to provide symptomatic relief in: gastric ulcer • duodenal ulcer • heartburn • gastric hyperacidity • gastritis • dyspepsia

when the patient prefers the convenience of a tablet, select

Silain-Gel® Tablets:

when the patient prefers a liquid, select

Silain-Gel® Liquid

Also available for the patient who needs an antifrothicant/antiflatulent agent only: **Silain®** (simethicone) Tablets

*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

Announcing the "Antgasid"

Silain-Gel®

Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide

Liquid: simethicone plus aluminum hydroxide and magnesium hydroxide

One dose does both: frees captured gas...neutralizes free acid

A·H·ROBINS A.H. Robins Company, Richmond, Virginia 23220



Drip stopped, Congestion cleared

For upper respiratory allergies and infections, up to 12 hours clear breathing on one tablet. Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely.

INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, rhinitis, conjunctivitis, and otitis. CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. DOSAGE: 1 Extentab morning and evening. SUPPLIED: Bottles of 100 and 500.

A·H·ROBINS

A. H. Robins Company
Richmond, Va. 23220

Dimetapp® Extentabs®

Dimetane® (brompheniramine maleate), 12 mg. phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories


Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
The many forms of Ilosone®
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900761

EDITORIALS

The Twilight Zone

I remember my grandmother saying that if she could have one wish it would be to "die with her wits on." Any poll of those over seventy will show that many are not so fortunate. For many in the twilight years of life the subtle anesthesia of senility dulls the mind, changes the personality, and perverts reality. Most difficult is that the transition from clarity to mental cloudiness is without awareness on the part of the affected individual. An unexplained change in attitude and reaction, a temporary loss of memory for recent events, and a sudden sharpness or suspicion which seems completely out of character are symptoms that can be refuted with no logical argument.

Walk through any hospital or nursing home and the evidence of these mental changes is all around us in the posture and complaints of the senile. The unmoving, the constantly moving, the querulous, the subdued, the seeking — all reflecting an unconscious turmoil, a need to be understood by the understanding. It is this understanding that is most difficult and demands the most of both laity and the medical profession. The great challenge is, in fact, to preserve mental health in the same manner that we have extended life expectancy through preventive health measures, elimination of disease, and surgical "miracles." Not too long ago pneumonia was considered the friend of the old for it took them swiftly and mercifully; a normal and frequently welcome euthanasia. Can we doctors honestly say that what we now have to offer is better? In some few cases, perhaps yes; but in the vast majority, the swinging door of senility slowly envelops the older patient in an irreversible cycle of confusion.

In an era when we have reached the moon, much remains to be done in the field of mental changes in the aged. Whether the answer lies in education, drugs, or environment no one is sure. To people who live on and on, the specter of senility is real and in ever increasing numbers its victims fill our hospitals and nursing homes. While the answer is not now apparent it is clear that much thought and effort must be given by American medicine toward a solution of the mental changes in the twilight zone of life.

—Robert B. Marin M.D.

The Unwashed And The Unfed

These days, our profession is being asked to pass judgment on the hippies and the yippies, the long-haired boys and the barefoot girls. Physicians by and large are members of the Establishment—it would have been hard to enter medical school otherwise. And since, by nature, the hippies are disestablishmentarians, they can't identify closely with the profession—and too often, *vice versa*. In fact, the unanswerable argument is always: just because we don't conform, don't have *your* values, doesn't mean we are wrong, does it? Some of the hippies, to be sure, give us wonderful clinical material (come to think of it, that's a great humanistic concept: people are "material"). Some of them do want a rain check from life. Others take it easy in a life of sweet idleness, figuring that since they have a ticket on the *S.S. Titanic* anyway, they might as well go first class.

And we have to understand, too, the other drop-outs from life who are simply seeking to "find themselves." While they are on the great quest—looking for themselves—they must by definition, be suffering from an "identity crisis."

Yet we doctors must be also interested in the fact that poverty breeds despair and this leads to human degradation, malnutrition, foul air, and exposure to dirt. Viewed in those terms, "poverty," though it never appears on a death certificate, is a significant factor in death. Of course, the really poor patient sel-

dom gets into private offices or private hospital rooms. But so long as we physicians prize our contact points with social problems, we might have a greater concern over hunger, atom bombs, and rats in tenements. We might even, perhaps, worry more about the unfed than about the unwashed.

The Doctor And The Alcoholic

While we agree that alcoholism is a disease, it is a disease which most physicians prefer not to treat. Why? To treat the acutely drunken patient, it is almost always necessary to go where he is — home, a hotel, a tavern, a police station, or the emergency room of a hospital. Making calls is getting out of favor these days anyway, and certainly it can be argued that in this case, there are others closer to the scene — hotel or jail physicians, or emergency room doctors. As for the chronic alcoholic — well, that's discouraging too. Except for the psychiatrists among us, most physicians don't have the time, patience or (let's face it) the interest to do the job probing beneath the rationalizations the patient gives for his excessive drinking. And we have been too often disappointed by the patient's failure to keep his solemn promise to abstain. ("How can he do that to *me*?" is a typical grievance when the promising patient falls off the wagon.)

There are some other facilities. Alcoholics Anonymous has a creditable record here, and while most physicians are not eligible for membership they are certainly welcome to assist AA, and to encourage a patient to enter this fellowship. New Jersey has state facilities — the outpatient ones through the State Health Department, and an inpatient unit at the Neuropsychiatric Institute at Princeton.* And a dozen general hospitals throughout the state do have special wards for alcoholics, at least for short-term care. Most private psychiatrists are willing to accept alcoholic patients. A promising federal program of alcoholic rehabilitation centers seems to have been axed-out of the budget in the recent economy wave.

Speaking through Milton Block, M.D., the American Medical Association recently told Congress about a "crying need" for community facilities to treat the alcoholic. The U.S. Senate has a subcommittee on alcoholism which is considering proposals to expand federal aid for alcoholism treatment and research. Subcommittee chairman is Senator Harold Hughes who makes no secret of his bout with alcohol in the past and his present membership in Alcoholics Anonymous.

Some of the witnesses before the subcommittee were people now prominent in their professions who described their battles with the bottle and recovery.

Dr. Block, describing alcoholism as the nation's worst drug problem, set forth the AMA's program:

1. Development of intensive treatment centers including clinics, detoxification centers, hospitals, and halfway houses.

2. Special education courses.

3. Legislation providing medical treatment of alcoholic patients.

4. Insurance coverage for alcoholism.

5. Hospital admission of alcoholic cases plus follow-up treatment.

"Alcohol has a special place in our society. Because of society's preoccupation with other drugs, alcohol's deleterious effects are commonly recognized only when a problem of alcoholism, with its psychological and physical dependence, is created," said Dr. Block.

Here surely is a challenge to any doctor, worthy of his best efforts as an individual practitioner!

* Write to the Alcoholism Control Program of the Division of Chronic Illness, Department of Health, P.O. Box 1540, Trenton, New Jersey 08625 for the outpatient service, and to P.O. Box 1000 Princeton, New Jersey 08540 for the inpatient alcoholism program.

The actions of the official Tincture and Extract of Belladonna result chiefly from their Atropine content . . . conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



ANTROCOL®

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.



Each tablet or capsule contains: Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

SUPPLIED
Tablet in bottles of 100, 500 and 5000
Capsule in bottles of 100, 500 and 1000

Caution: Federal law prohibits dispensing without prescription.

PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

DOSAGE: One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

Clinical supply available to physicians.

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals

Roche announces

Efudex®

(fluorouracil) cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex®(fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



./2/68—After 11 days of treatment. rythema is seen at site of keratoses. In ddition, numerous lesions not apparent rior to therapy have become manifest y sharply defined reactions. Intervening kin, also treated, shows no response to herapy.

:/19/69—One year after cessation of herapy. Skin appears clear with no evi- lence of scarring. Examination reveals ack of recurrence or the formation of iew lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new Efudex® (fluorouracil) cream/solution



For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning at the site of application. Other local reactions included dermatitis, scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice daily with a nonmetal applicator or suitable glove in an amount of the solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequence: erythema, usually followed by vesiculation, erosion, ulceration, necrosis and epithelization. The lower frequency and intensity of activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammatory reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of the lesion may not be evident for 1 to 2 months following cessation of Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions where complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or more was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 177 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

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ORIGINAL ARTICLES

Neurotic components exist in almost all human relationships, not surprisingly in marriages too. Of what do these components consist? Dr. Berney here offers some answers.

Neurotic Interaction In Marriage*

Ruth V. Berney, M.D./East Orange

From the days of Solomon (who solved the problem by multiplication) the institution of marriage has been beset with many difficulties. The eighteenth century English poet, Percy B. Shelley, wrote, "A system of association could not well have been devised more studiously hostile to human happiness, than marriage." This was a point on which his first wife agreed. She drowned herself in the Thames River, while he somewhat later chose the Mediterranean.

Though our forefathers were not much happier, marriage was popular then as now. Some 95 per cent of the adult population of the United States marry at least once. According to the National Center for Health Statistics, marriages have continued their ten year climb reaching over two million in 1969. Divorce statistics are but one indicator of marital unhappiness. Unresolved troubled marriages are at least as frequent as divorce, which occurs in one out of five marriages nationally, and two out of five marriages in California. There divorce laws have been updated. We have no statistics to document the number of desertions without divorce and stalemated marriage, where only the facade of a relationship exists. That seems to leave few marriages that work.

Years ago, one could rationalize that wives were cheap, motherhood was sacred, children were an economic asset, birth control was exceptional, and divorce was rare. Man retained the right of adultery, but tempered it with hypocrisy, while woman accepted her subordinate status more patiently. Today, our unhappiness has lost its patience and found its voice. Modern youth are seeking solutions. What will be the impact of the attitudes of our youth on the institution of marriage? Is the greater degree of sexual freedom making marriage obsolete? Will the sexual revolution sweep matrimonial morals aside? The marital bond and family living serve adaptive needs, such as the need for love, affection, and emotional support. Now, more than ever, these needs are not being met and unhappiness is felt. What is behind so much unhappiness? The marriage contract includes the unspoken expectations each person, knowingly or unknowingly, harbors. These have to do with wishes to be loved, which broadly include attitudes of mutual esteem and respect, as well as recognition of individual rights.

At this point in our cultural evolution the neurotic process is pandemic. Affected individuals suffered basic injury long before the marriage took place, and lack the ability to give and receive love.

During infancy and early childhood, and again during adolescence, various phases of libidinal organization are traversed. These two active periods are separated from one another by the period of latency, (roughly ages 6 to 11) during which the events of the

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earlier period fall victim to infantile amnesia. Each of these phases has been named after the erotogenic zone which is dominant in the experiencing of pleasure at that time. Anal, oral, and phallic personality characteristics are correlated to these periods. Complete organization is not reached until puberty, when a fourth or genital phase is attained. These phases do not succeed one another in a clear-cut fashion; they may coexist, overlap and/or fuse with one another. Even after experiencing all the phases, various ingredients of each of them persists, in lesser or greater intensity. These components are also in a continuous flux; integrating and regressing, according to the meshing of various forces, operative at a particular time. Thus, our particular symptoms and behavior are influenced by childhood "fixations" and unconscious (forgotten) memories of infant love experiences (oedipal complex). Maturity is equated with the successful resolution of all infantile conflicts, and with a full capacity to love. Such an ideal adult is equipped to bring into marriage an integrated blend of tender and sexual instincts which enable him to undertake a lasting and satisfying relationship with a mate; but alas, such maturity is rare. Marriage all too frequently offers a fertile soil in which the seedling of infantile fixations is germinated and sprouts. Reactivated deep-seated conflicts, centered about a parent or sibling in early childhood, reappear at crucial times during the life history of a marriage, whenever an event occurs which creates a new meaning in the relationship. Such an event can be the marriage itself, pregnancy, birth of a child, death of a parent, or even a physical illness.

In the following vignette, the marriage itself revived deep unconscious guilt feelings associated with oedipal wishes, resulting in decompensation of the wife's adaptive functioning. She consulted her physician because of diarrhea. This was found to be without physical cause and psychiatric help was recommended. Her history revealed a crippling dyspareunia which precluded ordinary intercourse. Extravaginal intercourse had been practiced during the courtship, with apparent satisfaction to both partners. Since the patient idealized virginity as a prerequisite for the acceptability of a bride, this practice was rationalized as a temporary expedient, awaiting marriage. When I first saw her, the marriage of less than a year was already threatened and, because of her symptoms, sexual contact was avoided. As a child, her permissive father had allowed her to share his bed on evenings when mother went out. She remembered being discovered by mother one night when both of them had fallen asleep watching T.V. She had had stomach aches when her parents quarreled, and finally had to have her appendix removed. After marriage, when she shared a bed with her husband, these conflicts were reactivated, causing dyspareunia and diarrhea. When major psychopathology exists, it becomes a vital and determining factor, and accounts for repeated failures in marriage.

Sexual symptoms commonly coexist with other manifestations of immaturity, interfering with satisfactory interpersonal relationships. The Victorian feminine role characterized by sexual inhibition has been altered today by social, economic, and cultural forces. In 1953, Kinsey[1] reported frigidity to be more common than impotence. Today, Masters and Johnson[2] define impotence in the male as being anything which falls short of eliciting an orgasm in his partner. Thus, there is bound to be repositioning (in more than the concrete sense of the word) on sexual matters. Modern attitudes have altered traditional male and female roles. The formerly feminine role characterized by sexual inhibition and passivity has changed to one of expectation of sexual gratification and activity.

Potency problems in both male and female may be symptoms of repressed conflicts which occurred during the developmental period. They are reflected in sick marriages by infidelity, switching, and in extreme cases by "menage a trois." Promiscuity and hypersexuality are indications of the earliest type of psychosexual fixation based on inordinately strong oral disposition. These people constantly seek "unconditional love" and can never be sat-

isfied. The sexual act is used to expiate the anxiety which feelings of aloneness generate.

In some people, love and hate are fused so that it influences their relationship in such a way as to make marriage a sadomasochistic nightmare. With repressed childhood memories of power struggles with a parent, or rivalries with siblings, any aggressive act or thought becomes blocked because of fear of retribution. In a male this is felt as castration anxiety.

Neurotics displace, convert, or project their conflicts. An externalized displacement is experienced as a phobia. If it is converted somatically and internalized, it expresses itself as physical disease. We physicians must realize that many of our patient's problems are related to covert neurotic interaction between husband and wife. These patients present themselves with many types of symptom complexes throughout the spectrum of medicine. Psychiatrically, any and all categories may be represented. The commonest is depression, with hypochondriacal anxieties. Frequent also are phobias, psychosomatic problems as well as actual organic disease.

Therapy of married couples and their problems is now receiving attention from all the disciplines concerned with human behavior. The clergy and the law have historically been involved since the beginning of marriage as an institution. Psychiatrists, psychologists, sociologists, marriage counselors, family agencies, child guidance clinics, and so on, are addressing themselves to this global problem. Marriage counselors focus primarily on the couple and their immediate and realistic (conscious) difficulties. In the last decade, psychiatrists and psychoanalysts have approached this problem, by developing specialized treatment modalities, aside from the individual psychotherapeutic one, which I have employed. The current status of marital therapy employs, at least, seven specialized forms of treatment. Briefly stated, the technics are:

1. Therapy or analysis of husband and wife in succession by the same therapist.

2. Simultaneous treatment of both spouses by the same therapist but in separate sessions.

3. Simultaneous treatment of both partners in joint sessions—conjoint therapy.

4. Treatment by two therapists, each of whom sees one spouse with the therapists in close communication—concurrent therapy.

5. Four-way sessions.

6. Group therapy.

7. Family therapy.

When the primary emphasis is on the treatment of the marriage, the couple's awareness of their problem is overt. Where an individual has symptoms of a physical or emotional order, the marital difficulties may be covert. In our clinic work various patterns of interaction take shape and have been described by several authors in the literature. Four main types, described by Mittleman[3] are as follows:

1. One partner is dominant and sadistic, the other submissive and masochistic.

2. One partner is emotionally detached, the other craving affection.

3. One partner is helpless and dependent, the other omnipotent.

4. Continuous rivalry exists between partners.

In the case presentations to follow, I have focused on these four types. The first is a situation where one partner was the sufferer, and the other a tyrant. An interaction between giving and receiving occurred. This appeared to work out for awhile. However, when the frustrations exceeded the coping abilities, a break in the defensive armament occurred and overt psychiatric symptoms erupted. Guilt over sexual impulses is often expressed by masochism at one level and delusions of persecution at a deeper level. When, in addition, such sexual aims are perverted, major pathology occurs. That these interactions fulfill deeply unconscious needs is evidenced by its repetitiveness.

Type One

An instance of where one partner is dominant and sadistic; the other submissive and masochistic, is exemplified by Mrs. A. She was first seen, medically, because of injuries, resulting from repeated accidents. These, as we

later reconstructed, occurred as a reaction to crises in her marriage. After each injury she would stabilize for awhile. Born in Europe, in a Nazi controlled area, she grew up in a labor camp within earshot of repeated bombings. In later adolescence she escaped to England where she went through her first stormy marriage, after which she emigrated to this country. Endowed with superior intelligence she had several times succeeded in making large amounts of money, but each time she lost most of it, through mistakes of judgment. When first seen she was complaining of her husband's infidelity and "unnatural sex practices." In addition he, like her first husband, who had brought his mistresses into the home, was beating her. The unnatural sex practices consisted of sado-masochistic acts, one of which was her husband urinating over her before intercourse. They practiced anal and vaginal intercourse as well as fellatio and cunnilingus. She accused her present husband of "spiking her drinks with sex stimulants," and of taking her money and giving it to his family. She had had a series of auto accidents and asserted that she was being pursued by "colored men" while driving, causing her to lose control of the car. During hospitalization (for a head injury) her husband did not bother to visit her. How she managed to find two husbands, each one willing and able to interact with her unconscious need for punishment is impressive. This patient was psychotic, with paranoid delusions and needed hospitalization for a time. Follow-up therapy was oriented toward reducing her acting out (accidents), lessening her guilt, and helping her achieve greater self-esteem. This was mediated through gratification resulting from doing things for her children, and her capacity for work. The sado-masochistic interactions then became less destructive. She remained married, still arguing, but now about money matters.

Type Two

One partner is emotionally detached and the other, usually the wife, craves affection. Before marriage the woman may be active, vivacious and pseudo-independent. The man will be attracted to her because of his need to feel detached, since intimacy evokes anxiety. He has developed aloofness as a defense against an (unconsciously) seductive mother. After marriage a vicious cycle is set up—the wife becomes frightened at being unloved and, needing more and more proof, leans further on her husband, who in turn reacts to her clinging with further withdrawal. Their dreams are shattered, repudiations, tears, arguments, and sullenness emerge and disruptions occur. The following history, of such a series of events culminated in the wife's becoming dizzy and having fainting spells. Mrs B. also developed pains in the chest, which precluded her continuing at work and which, because of separation from her second husband, made her dependent on her sons, with further dire results. She was bounced from one to another, and was being supported by a sister at the time of her consultation with me.

This patient was the younger of two sisters, and had four stepsisters, all older. While growing up, everyone babied her, especially her mother. She married and had two sons. While they were young, she was busy with them. Her husband worked two jobs and was always tired. Mrs. B. became restless and felt unnoticed and neglected. Her mother died while living in her home. After her mother's death she housed her stepfather, although she disliked him. The patient then developed chest pains. The doctors advised her husband that she needed care and attention, but he remained cold. He told her to go out alone. She began socializing and found other men attentive to her. She would invite them to "have sex" to feel loved although she didn't enjoy it. Finally she met her "Dream Man" for whom she divorced her husband. Shortly *he* became intolerant of her. This patient's dominant adult behavior was fixated at the oral level. She needed to be loved and fed. She had been a chain smoker before having the chest pains. She was obese, and worked as a telephone operator. Thus she related to the world orally in many ways. She had never recovered from her mother's death, which she was denying by keeping her alive through

living with the stepfather until his death and then by doing the things her mother had done, i.e. remarrying. Mrs. B. needed to feel united with mother to defend herself against the terrible anxiety of loneliness. To her, unconsciously, her vagina was another "oral" cavity, which she used by becoming promiscuous as a way of relating, and proving she was loved. She was driven to this behavior compulsively, and not on a genital level. Therefore she did not enjoy sex. In addition, (at the deepest level, unconsciously) she became united with other women this way, for this patient had never progressed, psychosexually, past the "reverse oedipal complex" in which the girl baby, just as the boy, loves the mother and wishes to possess her. This patient is being helped by understanding her needs and translating them realistically through gratifying them by help from rehabilitative resources in the community.

Type Three

Here is the neurotic interaction where one partner is dependent and the other omnipotent. The stronger partner reacts to his own dependency needs by pseudo strength (called reaction formation). In this way, a person avoids facing his own problems. Frequently the individual who feels helpless, acts this out through an illness, which then serves two purposes; (1) he (or she) gets the care and consideration needed and (2) he avoids the feelings of depression, to which, in fact, the illness is an equivalent. There are often histories of past vague illness which occurred at other stressful periods of their lives. Such a person, may be living out a "family romance" problem, which until it becomes worked through in psychotherapy, and thus resolved, accounts for the repetitiousness of their interpersonal relationships. This dependent partner selects a mate suited to his (or her) unconscious needs. In finding this mate, who, in turn needs someone to care for, a complimentary patterning occurs.

Such was the case with Mrs. C. At age 34, she was referred because of incapacitating "tension" headaches. Her illness was so crippling that she was unable to keep house for her husband and two children. She was brought for her initial visit by her husband, a self-made business man. The following story evolved: She was the middle child of a family of five. Her mother's first husband a gambler, had abandoned his wife while she was in confinement with their second son. After some years the mother remarried. When the patient applied for working papers, she discovered that her surname on the birth certificate was different from the one she was using at school, that of her mother's second husband. As treatment progressed, repressed memories erupted. She recalled that in her preschool years, there had been visitations by a man who always brought her presents. Memories of him faded away during her school years, after he had stopped coming. Throughout adolescence she was aware of yearnings for someone, and had recurrent dreams about Santa Claus. These yearnings, dreams, and memories, were about her real father, and fitted into the scheme of things, because she had always felt herself to have been treated differently than her two younger sisters were, by their father. She met and married her fiance after he returned from military service. He was generous with her, as with his own family, whom he employed in his business. She resented her in-laws but could not argue with her husband about it. Feeling that her in-laws disliked her, she isolated herself from them. Several months before her headaches became incapacitating, her mother had a depression and confided to her that she, my patient, was of "illegitimate birth!" With her mother's recovery she became sick. Mrs. C's sex life had always been meagre. She was disinterested and didn't enjoy it. She used to have bad dreams about her husband in which his arms were cut off, and she had been preoccupied with worries about him. After her memories about her father were revived, in therapy, she tried to find him and learned that he had died. Following this she would complain of crying spells which she felt she couldn't explain. Actually she was mourning her father. With this accomplished, she felt better and began to accept

her husband sexually. She needed guidance to help her keep the bedroom door closed, so that she could enjoy intercourse and experience an orgasm for the first time. She became active and effective in other ways as well, and treatment was discontinued with her move to a new home.

Type Four

The final type of neurotic interaction under discussion is one of continuous rivalry between the husband and wife for dominance. This is prominent in marriages in which the woman is striving for recognition; and resentments from past sibling rivalry situations, especially for women with brothers, revives narcissistic hurts that become reactivated. The changing status of women, educationally, economically, socially, and culturally, reinforces this problem. Frequently the man in such a marriage has feminine identifications and the woman, predominantly masculine identifications. The hostilities thus engendered have many opportunities to erupt. They insult and defeat each other, each wanting victory but instead of happiness they get depressed, and feel hollow and/or mutilated. In reality, each is dependent on the other, and each needs love and affection to feel whole. Thus they battle and repair their wounds, only to do battle again.

Today, the feminist movement for sexual freedom and equality is reaching its zenith. The most radical of these movements is preaching polygamy and community living. Premarital sexual experience is "routine." The complete package is contraceptive security and abortion on request. Female chauvinists, armed with scientific knowledge, point to recent biologic research, which has established that all human embryos begin life potentially female. After the first five or six weeks of gestation, the Y chromosome, through hormonal influence, diverts the genital-reproductive system into masculine development. They thus refute the "Eve out of Adam" myth, with the "Adam out of Eve" rebuttal. Masters and Johnson[2] have researched sexual physiology and documented the sexual prerogative for women, as well as men. This, again, is reinforcing the development of a new order in the institutions of dating, mating, expectations of fidelity, and even single "blessed eventedness."

In closing, I would like to include a poem to illustrate this conflict.

A Women's Liberation Movement Woman

By Judith Viorst

When it's snowing and *I* put on all the galoshes
While *he* reads the paper,
Then *I* want to become a
Women's Liberation Movement Woman
And when it's snowing and *he* looks for the taxi
While *I* wait in the lobby,
Then I don't

And when it's vacation and *I*'m in charge of mosquito bites and poison ivy and car sickness
While *he*'s in charge of swimming,
Then I want to become a
Women's Liberation Movement woman
And when it's vacation and *he* carries the trunk and the overnight bag and the extra blankets
While *I* carry the wig case,
Then I don't

And when it's three in the morning and the baby definitely needs a glass of water and *I* have to get up and bring it
While *he* keeps my place warm,
Then I want to become a
Women's Liberation Movement woman.

And when it's three in the morning and there is definitely a murder-rapist in the vestibule and *he* has to get up and catch him
While *I* keep his place warm,
Then I don't

And after dinner, when he talks to the company
While *I* clean the hroiler
(because I am a victim of capitalism, imperialism, male chauvinism, and also *Playboy* magazine),
And afternoons, when *he* invents the telephone and wins the Dreyfus case and writes War and Peace
While *I* sort the socks
(because I am economically oppressed, physically-exploited, psychologically mutilated, and also very insulted)
And after he tells me that it is genetically determined that the *man* makes martinis and the *lady* makes the beds
(because he sees me as a sex object, an earth mother, a domestic servant, and also dumber than he is),
Then I want to become a
Women's Liberation Movement Woman

And after I contemplate
No marriage, no family, no shaving under my arms, and no one to step on a cockroach whenever I need him,
Then I don't

Summary

At this point in cultural evolution the neurotic process is almost universal. Marital prob-

lems are the reflection of underlying personality disturbances in one or both partners. The basic components of neurotic interaction in marriage are shown in several perspectives: (a) neurotic choice of mate; (b) reciprocal neurotic patterns; (c) sexual symptoms; and (d) child rearing problems.

A schooled approach to the study of genetic, dynamic, and unconscious aspects is required to understand these disturbances and how they operate in the personality of an individual and in the marital interplay.

A review of basic theory of personality formation and the realization that such development is uneven and changing throughout an individual's lifetime has been discussed. A comparison of male and female psychological development were highlighted in elucidating the marital interaction. Against a backdrop of broad cultural, socio-economic stresses, kinship relationships, unconscious drives, narcissistic needs, and unfulfilled dependency wishes, symptoms arise. These anxieties and fears are exaggerated and distorted by a world of changing values and discordant subcultures. We "act out" our problems on those closest at hand. The hostile-dependent-sadomasochistic interaction is but a facade of deeper internal and interpersonal problems. Case illustrations show how these unhappy unions present themselves as symptoms in every psychiatric category. One is confronted with a diagnostic and therapeutic challenge in the analysis of the components of the problem, as it varies with the character structure, ego defenses, repetition compulsion, unconscious fantasies, and ego strengths of each individual. By first exposing the hostile interplay, and then replaying the forgotten infantile situation, a more mature personality emerges and often helps to salvage the marriage.

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Outlook for Heart Transplants

The National Heart and Lung Institute has recently predicted that the demand for heart transplants will increase beyond the present level of about 100 a year and exceed the number of the organs available. This report on cardiac replacement also said:

—Fewer than 16 per cent of the 200,000 Americans under 65 who die each year from heart disease are good candidates for transplants.

—Rejection of the transplanted heart will remain the major barrier to prolonged survival.

—Development of an artificial heart is now a distinct possibility.

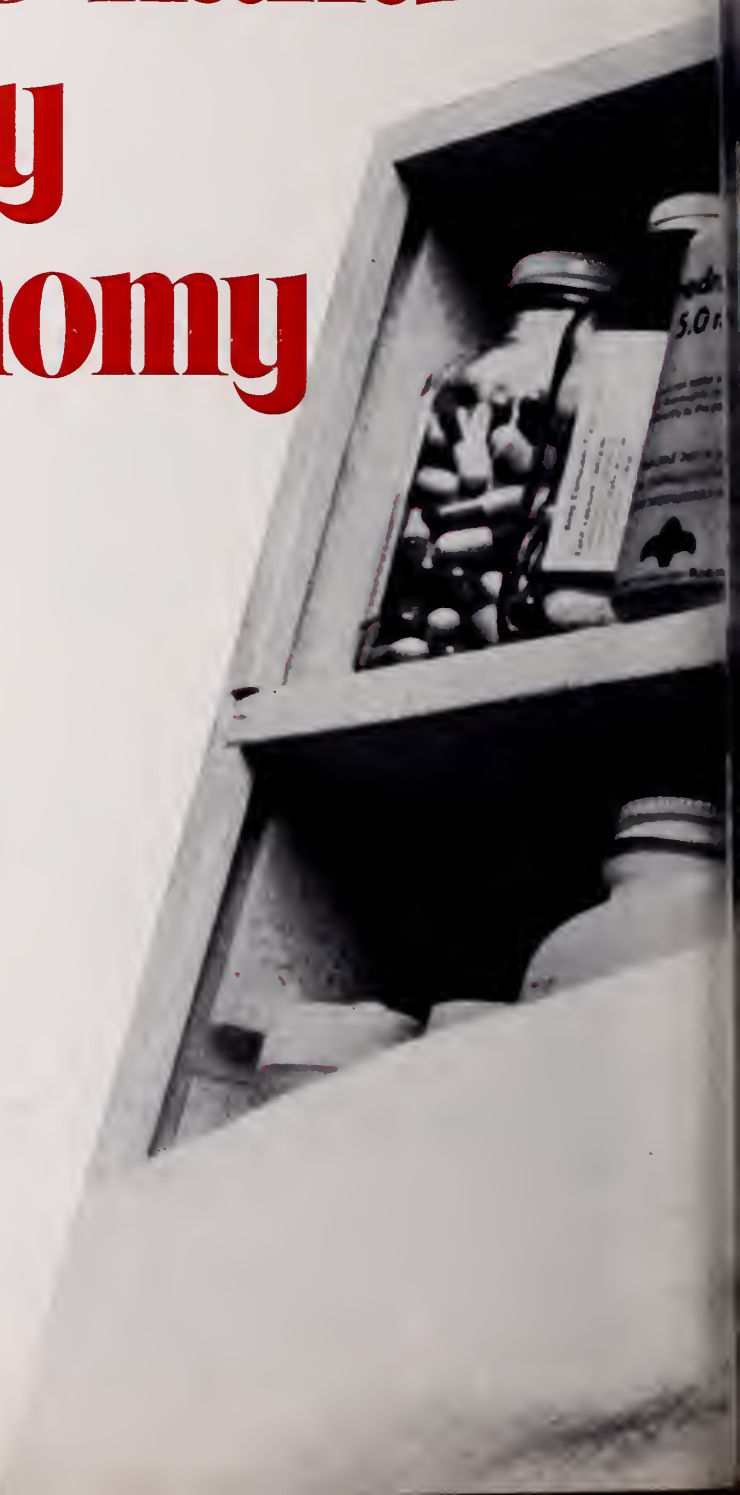
—A new definition of death is needed.

—Total transplant charges for 36 patients averaged $18,694 per patient.

—Heart transplants have been done on 148 patients, with 23 persons still surviving, 16 of them in the United States.

—More than 32,000 heart disease victims can be considered transplant candidates, but there are only about 22,000 possible donors a year.

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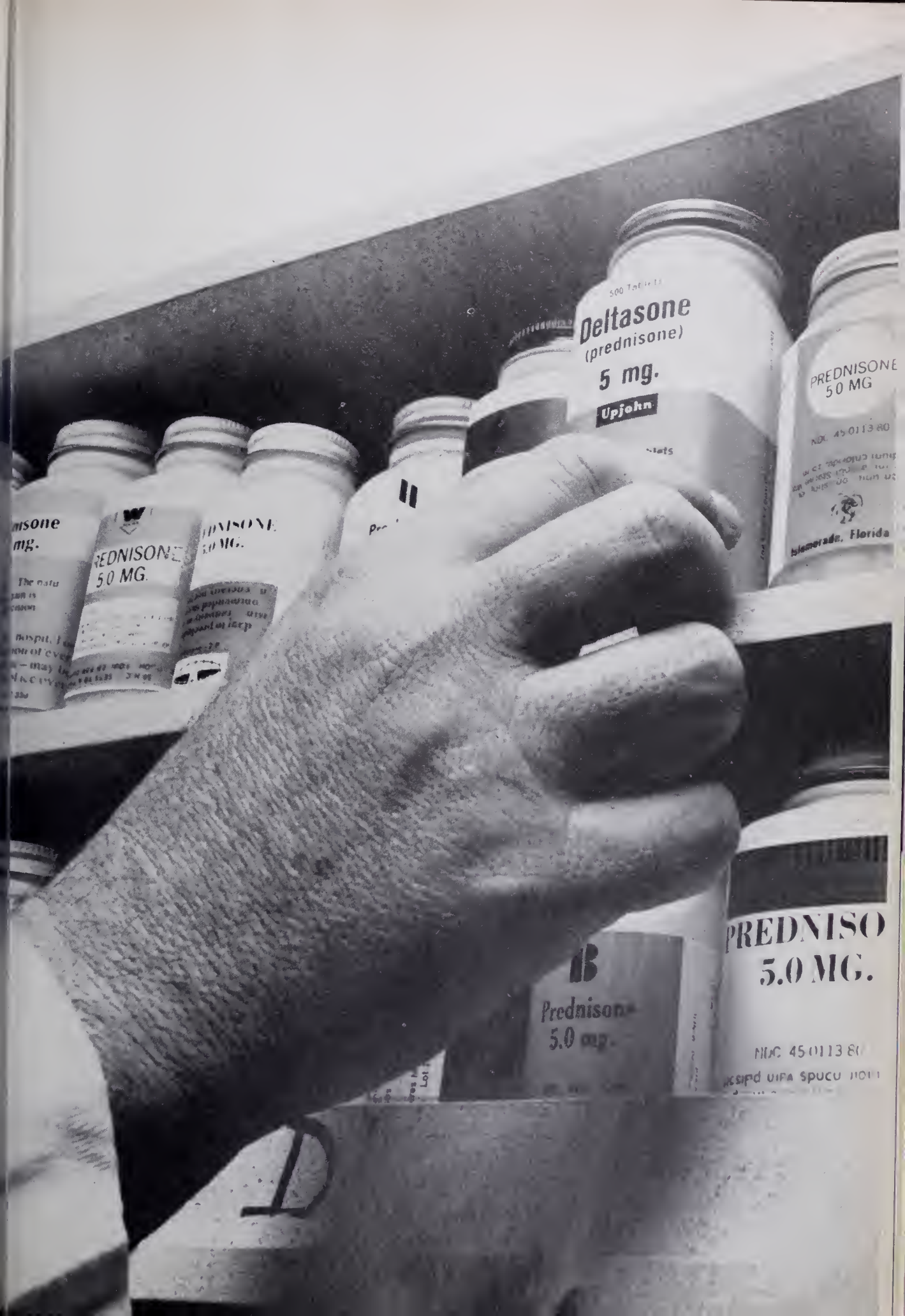
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Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this effec in mind and perform periodic serum potassium determinations ir patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angiitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

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Liquid roach killer can be a dangerous source of parathion. All victims here were successfully treated, but the doctor must be aware of the diagnosis and familiar with the treatment.

Parathion Poisoning In A Family*

Donald S. Kwalick, M.D. and Barbara Surowiec, M.D./Trenton

Phosphoric acid esters have been used increasingly as insecticides over the past 20 years. Examples of these organophosphates include: chlorothion, dimethyl dichlorovinyl phosphate (DDVP), malathion, parathion, phosdrin and tetraethyl pyrophosphate (TEPP). The acute effects of organic phosphorous insecticides have been well reviewed.[1, 2] Accidental exposure to parathion has caused major outbreaks of fatal intoxications throughout the world in the past decade.[3, 4, 5] Unlabeled or improperly labeled parathion as a major cause of poisoning in children has been well described.[6, 7]

This report describes the intoxication of three children after their home was sprayed with a liquid "roach killer" purchased from a street corner salesman. Wyckoff, *et al.*[7] and Davies[8] mention peddlers of parathion "roach powder;" but, to our knowledge, the sale of bottled-liquid parathion by itinerant salesmen has not been previously reported in the literature. These cases emphasize the high index of suspicion which must be present if organophosphate poisonings are to be accurately diagnosed and vigorous, rapid therapy instituted.

Case #1—A two-and-a-half year old Puerto Rican boy was admitted to the emergency room with a sudden onset of dyspnea, and difficulty in swallowing, after his noon meal of tuna fish and cocoa. Preliminary diagnoses were botulism and aspiration of a foreign body. Botulism was thought of because of the canned tuna, but the chronologic relationship between the meal and onset of illness (1 to 3 hours), as well as the clinical findings, were inconsistent with botulism. The child appeared pale and drowsy, with some circumoral cyanosis, but he was otherwise normal. Radiographs and physical examination failed to reveal evidence of a foreign body. His condition deteriorated with progressive loss in consciousness. He became comatose with miotic, non-light reactive pupils: hypersalivation; rhonchi over both lung fields; decreased deep tendon reflexes; and coarse tremors of his extremities. His pulse rate was 120 per minute and his body temperature dropped to 95. Blood pressure was 80/50. Respirations became shallow with short periods of apnea, necessitating endotracheal intubation. Laboratory data included a hematocrit of 37 per cent and hemoglobin of 11.2 Grams. Blood urea nitrogen; serum electrolytes, calcium, and phosphorus; as well as urinalysis were normal.

Shortly after this child was admitted, two other siblings complained of drowsiness, vomiting, and abdominal pain, and intoxication was suspected.

Case #2—This four year old brother was admitted fully alert, with hypersalivation; rhonchi in both lungs and occasional tremors and twitching of his extremities. Within one hour he was comatose. In two hours he was unresponsive to painful stimuli and had severely constricted pupils, greatly increased salivation, and more frequent twitching of the extremities. His pulse rate was 134 per minute, body temperature 96.8, blood pressure 110/80 and respiratory rate of 28 per minute.

Case #3—This six year old girl was admitted with pallor, moderate diaphoresis and slightly miotic but light-reactive pupils. She had no hypersalivation and had only one episode of tremor in the extremities. She had a brief syncopal episode in the emergency room prior to admission but never became comatose. Vital signs were stable, with a pulse rate 110 per minute and body temperature 98.6. Blood pressure was 120/60 and respiratory rate was 28.

Chest X-rays; CBC; urinalysis; serum calcium, phosphorus, electrolytes; BUN; carbon dioxide content were within normal limits in patients #2 and #3.

Case #4—A seven year old sister, who was asymptomatic, was also admitted to the hospital for observation.

The sudden onset of illness in these previ-

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TABLE I

Cholinesterase Levels by Date in Four Siblings

		Cholinesterase Levels (by pH Stat—International Units*)						
	Case*	7/30/69	7/31/69	8/12/69	9/12/69	10/3/69	11/7/69	2/13/69
Red Blood Cell*	1	1.7‡	9.9§	9.4	7.6	7.2	7.2	8.3
	2	1.6‡	8.8§	11.1	7.1	6.7	9.6	8.6
	3	1.3‡	6.7§	7.1	8.3	6.5	9.1	5.7
	4//	6.2	5.8	8.3	6.9	7.8	9.5	8.1
Plasma*	1	0.4‡	2.1§	5.5	7.5+	5.1	5.5	7.3
	2	0.4‡	1.5§	3.7	3.5	3.2	3.3	3.4+
	3	0 4‡	1.0§	3.6	3.1	3.5	4.0	3.7
	4//	1.7	2.0	4.0	4.2	3.4	4.4	4.1

* Normal values RBC—8-16, Plasma—3-6 } International Units

\+ hemolyzed specimen

‡ before pralidoxime chloride administered

§ after pralidoxime chloride administered

// received no pralidoxime chloride

TABLE II

Urinary Paranitrophenol Excretion* by Date in Four Siblings

Case #	7/30/69	8/12/69	9/5/69	10/3/69	11/7/69	2/13/70
1	5.29	0.94	3.2	0.72	0.49	0.26
2	+	1.31	1.53	0.62	0.18	0.16
3	5.13	0.88	0.85	0.26	0.29	0.22
4	7.67	1.53	1.33	0.46	0.21	0.14

* In ppm, significant level more than 0.22 ppm, corrected to osmolality of 1000 mosm.

\+ Urine not available.

ously well children indicated some sort of poisoning despite the lack of any history initially of exposure to chemicals or drugs. Careful inquiry through an interpreter revealed that the father had sprayed a liquid "roach killer" throughout the home one day prior to admission.

Organic phosphate and carbamate poisoning were suspected. Three one-milligram doses of atropine sulfate were given to each symptomatic patient (Cases #1, #2, #3) at one-half to one hour intervals. Blood obtained before atropine administration revealed marked depression of red blood cell and plasma cholinesterase levels in the three symptomatic siblings, and mild depression of cholinesterase levels in their oldest asymptomatic sister. Two hours after atropine was begun, two doses of 0.5 Grams of pralidoxime chloride‡ at one hour intervals were given intravenously to the brothers (Cases#1 and #2). The younger sister (Case #3) received one 0.75 Gram dose of pralidoxime chloride‡ intravenously. There was rapid clinical improvement after this therapy. The other sister (Case #4) received no treatment and she remained completely asymptomatic.

The children recovered uneventfully and were discharged on August 4, 1969.

‡ Pralidoxime chloride is trade-named Protopam Chloride—2 PAM.

Laboratory Results

Cholinesterase—Red blood cell and plasma cholinesterase determinations by the method of Nabb and Whitfield[9] were depressed in all four siblings. Their plasma cholinesterase increased the following day. The day after admission the asymptomatic sister (Case #4) had a slight depression of red blood cell cholinesterase from 6.2 to 5.8 International Units and a slight rise in plasma cholinesterase from 1.7 to 2.0 International Units. (Table I) Both of these changes are insignificant and could be attributed to either physiologic and/or laboratory variability.

A secondary decrease in cholinesterase (Cases #1, #2, #4) was noted six weeks after initial contact with parathion (Table I). Cholinesterase levels of the parents on the day of admission were within normal limits.

Parathion—Pesticide analyses were performed by electron capture gas liquid chromatography with a tritium detector. We found the unused "roach killer" from the originally purchased bottle to contain 50 per cent parathion. Analyses of sera for parathion were nega-

tive at time of admission and inconclusive afterwards. Analysis of food consumed at the noon meal on the day of admission revealed 280 to 4800 ppb in tuna fish and 50 ppb in cocoa. Gastric contents of the two brothers (Cases #1 and #2) on day of admission contained 118 and 106 ppb, respectively. Serum parathion levels on the day of admission were 208 and 105 ppb in the father and mother, respectively. Six—70 per cent isopropyl alcohol swabs were obtained from exposed surfaces in the apartment and were analyzed for parathion after direct hexane extraction. These samples were for identification purposes only and demonstrated parathion peaks that were off the recording scale. Repeat swabs six weeks after initial spraying revealed 1 to 500 micrograms of parathion per square foot remaining in the home.

Paranitrophenol—Urinary paranitrophenol (PNP) determination, using the technic of Elliot, *et al.*,[10] revealed very significant excretion for six weeks, ranging from 0.85 to 7.67 ppm over this period (Table II). The father and mother had 5.5 and 2.6 ppm PNP excretion, respectively, on the day of admission of their children to the hospital.

Epidemiology

The father had received the "roach killer" in a spray gun from his landlord, who purchased the bottled solution from a street corner salesman. The liquid was sprayed rather heavily on the baseboards, shelves, and walls of the bathroom, kitchen and living room during a hot, humid evening. The children were out of the house during the spraying and returned two hours later. They were well until about 18 hours from time of spraying. This long delay would suggest little or no dermal contact, as parathion is rapidly and easily absorbed through the intact skin, especially under the conditions of high temperature and humidity which existed at the time.[11] However, we cannot completely exclude the possibility that absorption of small amounts of parathion through dermal contact and inhalation coupled with the ingestion at the noon meal were responsible for the poisoning.

Hayes[12] reports 2 milligrams of parathion capable of killing five to six year old children. Although the amounts of parathion absorbed by our patients were estimated to be less than 2 milligrams, the levels found in their food and environment were sufficient to cause their symptoms. The levels of parathion found in the parents' serum (208 and 105ppb) were higher than levels reported by Wyckoff[7] (115 ppb) and Bernstein[6] (77 ppb) in children poisoned with parathion. Nevertheless, the adults remained completely asymptomatic. Unfortunately, we were unable to quantitate serum parathion levels in the four children, due to interference possibly from medication, but levels of serum parathion and urinary PNP of the parents emphasizes the increased susceptibility of young children to parathion.

The continued excretion of PNP was unusual. This parathion metabolite is usually completely excreted in the urine within 48 hours after ingestion of parathion.[13, 14] Their prolonged PNP excretion may have been due to absorption from dermal reservoirs[15] or re-exposure to parathion. The latter possibility was unlikely, as they were away from their home for two weeks after hospitalization. After re-entering their home, some three weeks after the spraying, there was a marked increase in the youngest child's PNP and little change in the other three children's PNP excretion. This intrigued us, because, after the original poisoning 70 per cent isopropyl alcohol swabs were obtained from various exposed surfaces in the home. These samples were for identification purposes only, but demonstrated parathion peaks that were off the recording scale of the gas chromatograph, indicating that large amounts of parathion were present. For this reason, the parents were instructed and supervised in using a 6 to 10 per cent sodium carbonate solution to wash down all exposed areas. We felt that this moderately strong base would hydrolyze much of the parathion.

When the secondary rise in PNP excretion was noted, a resampling of various areas in the home was performed. Significant levels of parathion, ranging from 1 to 500 micrograms per square foot, remained in these areas. Absorption of or re-exposure to this persistent parathion could certainly account for the increased PNP excretion. We found that the youngest brother (Case #1), with the greatest increase in PNP excretion, consistently dropped food on the floor and returned later to eat this possibly contaminated food. Both brothers spent a great deal of time on the floor, playing. However, for two weeks the

children were completely away from re-exposure, yet continued to excrete PNP during their hospitalization and recuperation away from the home.

Quinby[14] reported a patient who excreted PNP for seven days after dermal exposure and mentions unpublished cases demonstrating similar excretion patterns. However, to our knowledge our cases represent the longest PNP excretion period[12] after ingestion and possible dermal exposure. The findings of significant levels of parathion in the food and in the gastric contents of the two boys suggest a predominantly oral route of exposure. Skin samples for parathion were not obtained and would have been useful in retrospect, but each child was thoroughly washed with soap and water on admission and daily during hospitalization.

Parathion can persist in supposedly empty containers in open fields for up to a year[16] and, therefore, its presence in the home was not surprising. Parathion's persistence is emphasized by the fact that after the home was washed with 6 to 10 per cent sodium carbonate, the parathion remained in the washed areas. This moderately strong base did not hydrolyze the parathion as we had expected.

Treatment

The recommended dosages of atropine sulfate in organophosphate poisoning are 2 to 4 milligrams in adults and .015 to .05 milligram per kilogram in children intravenously, every five to ten minutes until signs of atropinization — (dry, flushed skin and tachycardia)—appear. Atropine should not be given until cyanosis is overcome, as ventricular fibrillation may occur. These doses of atropine are much higher than usually employed due to an increased tolerance for atropine in persons poisoned with organophosphates.[1, 6] In our cases, however one milligram of atropine sulfate intravenously, given three times at one-half to one hour intervals, was sufficient. Higher and more frequent doses of atropine were not given, due to the already present tachycardia. Pralidoxime‡ chloride therapy resulted in rapid clincal improvement and five-fold increase in red blood cell cholinesterase. Pralidoxime is *not* indicated in carbamate poisoning, and we awaited cholinesterase levels before administering it. The markedly depressed cholinesterase levels indicated organophosphate rather than carbamate poisoning was present. The efficacy of pralidoxime chloride in increasing cholinesterase activity in organophosphate poisoning was seen by the difference between the cholinesterase levels of the treated siblings (Cases #1, #2, #3) with their untreated older sister (Case #4) (Table I).

Diagnosis

The importance of a careful history cannot be overemphasized. Indeed, in our first case, the initial diagnosis was foreign body aspiration. Not until we obtained further history and saw the siblings become ill, did we suspect possible organophosphate or carbamate intoxication. When the history of exposure is absent, the clearest indicators of cause are the signs of parasympathetic overstimulation.[7] Miosis is usually present, but Davies[8] reports 30 per cent of the cases presenting with mydriasis. Note that the two severely intoxicated patients (Cases #1 and #2) had dry, warm skin and no lacrimation. This is contrary to the profuse sweating and lacrimation expected with parasympathetic hyperactivity. These patients did, however, have excessive salivation, extremely miotic pupils and "wet" lung fields. The other patient (Case #3) demonstrated no lacrimation or salivation but was diaphoretic and had miotic, light-reactive pupils.

The medical practitioner should think of the possibility of organophosphate poisoning in patients with symptoms like these. Such suspicion should certainly be entertained in children with signs of parasympathetic overstimulation. This is especially true in areas where pesticide poisoning is a rare occurrence.

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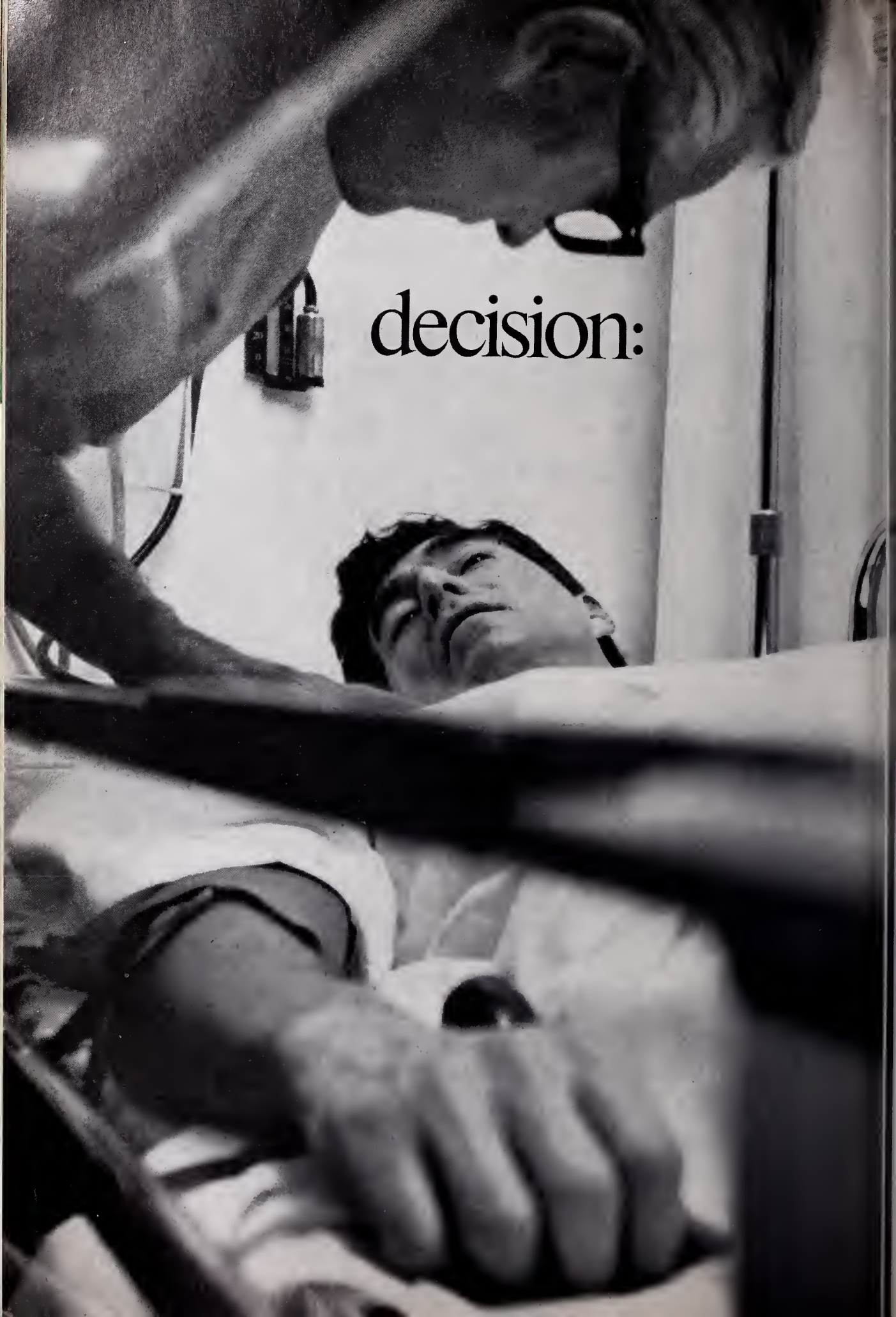
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A new method of paying for health care services designed to get increased value for the Medicare health care dollar is now being tested in New York City under a contract with the Health Insurance Plan of Greater New York (HIP). The aim is to provide strong economic incentives to find the most economical and efficient way of providing a full range of health care services to Medicare beneficiaries. Incentive payments are designed to encourage and reward HIP for planning and carrying out patient care policies that will make the best use of hospitals, extended care facilities, and home health agencies.

One of the major objectives is to encourage the use of alternatives to high cost hospital care suitable to each patient's progressive condition. In this program Medicare reimbursement for a full range of health care services (including doctor's care, hospital care, and all other services) will be made through a single capitation payment. Any savings, representing the difference between the health care costs of Medicare beneficiaries who are HIP members and those who are not, will represent incentive payments to HIP.

For measurement purposes, costs of a group of HIP Medicare beneficiaries will be compared over a one-year period with costs of a control group of non-HIP Medicare beneficiaries. New measurement groups will be formed for each of the three years covered.

A special medical care planning and administrative unit will be established by HIP to supervise the experimental program. This unit will assess current patterns of medical care, to develop and implement guidelines for modifying these patterns, to establish the necessary working relationships with hospitals and other institutions, and to evaluate the progress of the experiment.


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Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

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Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

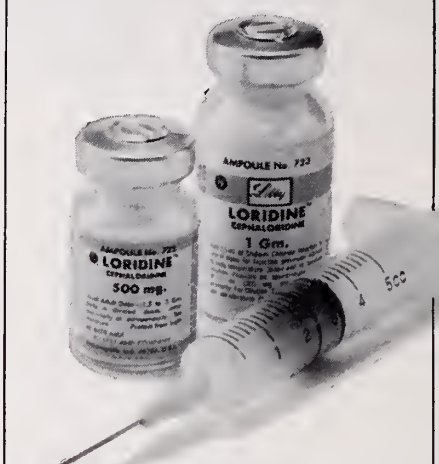
How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [0821691]

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Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

The aspirin tolerance test is found not to be a reliable diagnostic index of any coagulopathy, such as the Minot-von Willebrand Syndrome.

The Aspirin Tolerance Test*

Does It Have Clinical Value?

Stanley M. Becker, M.D./Perth Amboy
Mona Shangold/Durham, N. C.**

Quick[1] described the aspirin tolerance test in 1966 and found it useful in the diagnosis of the Minot-von Willebrand syndrome. Several patients with this malady showed greatly prolonged bleeding times (Duke) following the ingestion of 0.6 Grams of acetylsalicylic acid whereas their bleeding times *before* medication were normal. A small proportion of "normals" also show poor aspirin tolerance but they do not have the other clinical, laboratory (decreased Factor VIII concentration and reduced platelet adhesiveness), or familial aspects of the disease. This report describes the results of testing 20 "normals" by the Duke and Ivy Bleeding Times before and after aspirin.

Materials included two spring-loaded lancets #3644 (Arthur Thomas Company, Philadelphia, Pennsylvania), 70 per cent Isopropyl Alcohol, grade 1 filter paper (7.5 cm. in diameter), and Acetylsalicylic Acid Tablets—5 grains (0.3 Grams).

Each of 20 subjects (who had no personal or familial history of any bleeding diathesis) had an Ivy and Duke Bleeding Time done before and two hours after ingesting 0.6 Grams of acetylsalicylic acid. The spring-loaded lancets were adjusted to puncture to a depth of 3 millimeters. The patients were kept in a fasting state (except for the fluid used to swallow aspirin) before and during the tests. A careful history of any drug intake was elicited from each subject. The relative subjective pain of each test, the nature of the blood flow, the number of punctures that resulted in no bleeding, and the four bleeding times, were recorded.

The mean initial Duke bleeding time was 2.7 minutes with a normal range of 0 to 5.5 minutes while the mean Duke bleeding time 2 hours after the ingestion of aspirin was 4.5 minutes with a normal range of 0-11.1 minutes. Only one subject had an initial Duke bleeding time higher than the normal range. She was the only one with a Duke bleeding time *after* aspirin less than *before* it. In one other case there was no difference. A possible explanation is that a vessel larger than capillary size was punctured. The differences between the two Duke bleeding times varied from 0 to a maximum of 5 minutes and from 0 to 300 per cent. Those with 100 per cent or more difference had activated PTT's (Partial Thromboplastin Times) performed, all of which were within normal range (35 to 45 seconds).

The mean initial Ivy bleeding time was 2.8 minutes with a normal range of 1.8 to 3.8 minutes while the mean Ivy bleeding time 2 hours after taking the aspirin was 6.3 minutes with a normal range of 1.3 to 11 minutes. Those with greater than 100 per cent difference had activated PTT's done. All were within the normal range. Fourteen subjects were male and 6 were female with an age span of 16 to 54. The Duke tests (ear) were more painful in 13 individuals, less painful in one, and equally painful in six. This may be related to the use of spring-loaded lancets or the technic used.

* This manuscript was received by *The Journal*, MSNJ on January 23, 1970.

** Dr. Becker is the pathologist at the Institute of Laboratory Medicine, Perth Amboy (New Jersey) General Hospital. Miss Shangold is a medical student at the Duke Hospital in Durham, North Carolina.

In four cases, the puncture site during one of these tests did not bleed spontaneously but did bleed after touching the filter paper to the puncture site. Five other individuals had one or two unsuccessful punctures, i.e. punctures which were not followed by any bleeding. A possible explanation of this is poor blood supply in the puncture site. Other authors (Didisheim and Bunting)[9] have also described this problem. They recommended modifying the Ivy test by increasing the depth of the puncture. Borchgrevink and Waaler[20] suggested lengthening the "incision" to 10 millimeters while limiting the depth to one millimeter for their "primary" bleeding time. Twenty-four hours later they provoked bleeding by carefully removing the clot to obtain a "secondary" bleeding time. This modification has the obvious disadvantages of being objectionable to the patient and requiring more than 24 hours.

Bleeding was described as 1+ for minimal, 2+ for moderate, 3+ for brisk and 4+ for profuse flow. Brisk or profuse bleeding occurred only five times before aspirin and 13 times after aspirin.

The tests were done according to the standard procedures described by Altman and Dittmer.[23] The tests were the responsibility of one medical student whose primary concern was this project. Punctures were made on skin surfaces that were held taut after they had been cleansed with alcohol sponges and air dried. Spring-loaded lancets were used in an attempt to standardize the depth of puncture.

Only one of the patients used any medication frequently. She took APCs every day.

Although this is a relatively small series, the difficulties in attempting to interpret bleeding times (Duke or Ivy) before and after aspirin, are obvious. None of these 20 volunteers have Minot-von Willebrand syndrome or any other coagulation defect and yet many showed significant increases in their Duke or Ivy bleeding times after aspirin. Only six of the 14 subjects who had more than 100 per cent increase in their Ivy bleeding times also had more than 100 per cent increase in their Duke bleeding times.

We derive little comfort from the difficulties of others with bleeding time determinations. Roskam[11] obtained a bleeding time of 3 minutes in one ear and 48 minutes in the other ear of one individual with the Minot-von Willebrand syndrome. Buchanan and Leavall[12] reported a patient with a Duke bleeding time of 17 minutes in one ear and 180 minutes in the other. Pitney[13] repeated Duke tests on one patient and found that they varied from 3 to 30 minutes. Kaneshiro *et al.*[25] found marked variation in the bleeding times two hours after aspirin in patients with known clotting disorders, e.g. mild and severe hemophilia A and hemophilia B.

Factors which may influence the results of bleeding time determinations during routine testing include the following:

1. Size, depth, and rapidity of puncture.
2. Skin tension at puncture site.
3. Blood supply at puncture site.
4. Direction of incision.
5. Ambient temperature and humidity.
6. Ingestion of medication.
7. Manner of touching filter paper to bleeding site during test.
8. Grade of filter paper.

Whether tests with so many variables in their performance, with wide variability in their results, and with little reproducibility even in the same patient can be of any value is open to question.

Summary and Conclusion

Twenty aspirin tolerance tests were performed on 19 normal subjects using the methods of Duke and Ivy. Eight showed an increase of 100 per cent or more in their Duke bleeding time. Fourteen showed an increase of more than 100 per cent in their Ivy bleeding time, and six showed an increase of 100 per cent or more in both bleeding times two hours after ingestion of 0.6 Grams of aspirin. These subjects had no clinical or laboratory evidence

of any coagulation defect. It is therefore impossible to establish meaningful normal ranges for the Aspirin Tolerance Test and it should not be relied upon as a useful diagnostic index of the Minot-von Willebrand Syndrome or any other coagulopathy.

—A bibliographic list of 29 citations will be found in the author's reprints.

530 New Brunswick Avenue (Dr. Becker)

Local Treatment of Alcoholics

Federal grants to help provide local alcoholism treatment and rehabilitation services have now become available. The National Center for Prevention and Control of Alcoholism of HEW's National Institute of Mental Health will administer the new grant program. This is a landmark step toward developing a desperately needed national network of community-based treatment and rehabilitation programs for alcoholics. Community programs will help not only the estimated six million persons afflicted with alcoholism in the United States today, but also over twenty million family members and others who must suffer because of an alcoholic's illness.

Grants to assist communities in providing alcoholism services were authorized by PL 90-574, but until now no funds have been available for such grants. More than three million dollars are now available. An additional six millions for this purpose are included in the President's budget request for fiscal 1971.

The grants help cover the salary costs of professional and technical staffs of new comprehensive alcoholism treatment services, provided by either a community mental health center or another qualified public or private nonprofit organization in the community. Grants may be awarded to these agencies for a period of eight years on a matching-funds basis.

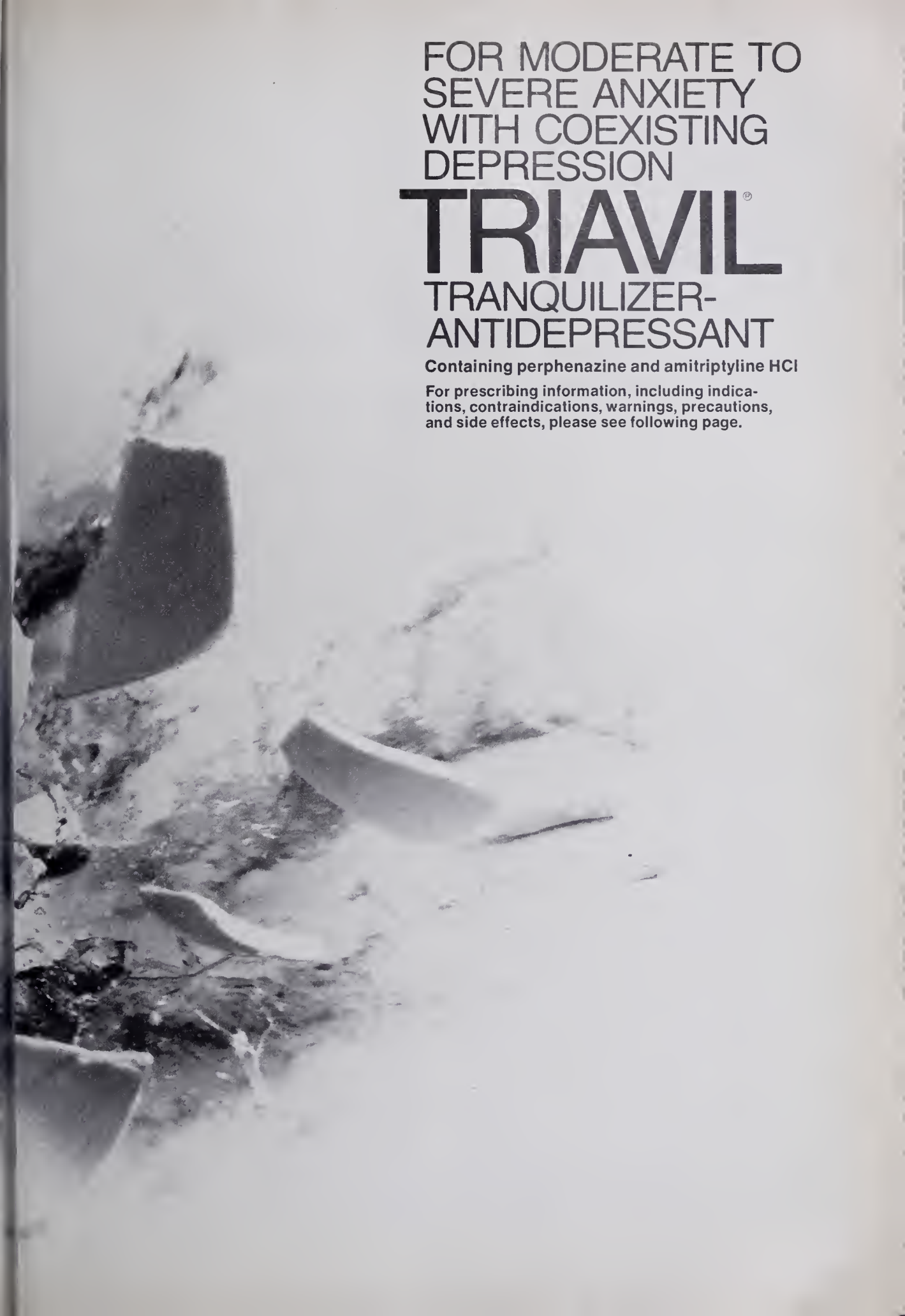
Agencies receiving grants must offer a comprehensive alcoholism treatment program, including the following five essential services: (1) inpatient hospital care; (2) outpatient services; (3) intermediate services, such as a halfway house, day or night hospitalization, or other sheltered care; (4) emergency service, available on a 24-hour, 7-day-a-week basis for medical, psychiatric, and social emergencies; and (5) consultation and education services related to prevention and treatment on alcoholism.

Federal matching funds may also be used to help provide additional services, such as vocational, educational, or social services related to rehabilitation of alcoholics; for in service staff training programs; or for research and evaluation of alcoholism services provided. Limited funds are also available for construction of treatment facilities.

Further information or application kits for the new grants may be obtained from the National Center for Prevention and Control of Alcoholism, National Institute of Mental Health, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015.

BREAKUP—symbol of the impact of emotional stress
But when the stress exceeds transient rage or depression—and settles into a chronic mixed anxiety depression state—combined tranquilizer-antidepressant therapy could be indicated.





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TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.

FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

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TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

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INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; pregnancy; and in patients with known hypersensitivity to phenothiazines or amitriptyline. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least two weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response. Do not give concomitantly with guanethidine or similarly acting compounds since it may block the antihypertensive effect.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be increased.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Use with caution in patients with glaucoma and those with problems of urinary retention. Perphenazine can lower the convulsive threshold in susceptible individuals. It should be given with caution to patients with convulsive disorders. Dosage of the anticonvulsive agent may have to be increased. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients who have previously exhibited severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation. Significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypertension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; impotence; increased appetite and weight gain; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, stomatitis, blurring of vision, reversible dilatation of the urinary tract, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information, consult your MSD Representative or see the package circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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Malignant tumors of the kidney, testis, and bladder are generally considered almost hopeless. However, as here reported, chemotherapy does offer hope in selected cases.

Chemotherapy Of Urologic Neoplasms*

Bernard J. Koven, M.D./Englewood

Adenocarcinomas of the Kidney: Modern cancer chemotherapy began with the use of nitrogen mustard shortly after World War II in Hodgkin's disease and other malignant lymphomas. The nitrogen mustard derivatives have had a useful role in certain solid tumors including neoplasms of the ovary and breast. However, these agents have only been occasionally successful in the treatment of renal carcinoma. In 1967, Woodruff *et al.*[1] reviewed 61 reports dealing with 35 different chemotherapeutic agents used in the treatment of advanced renal carcinoma. All told 270 patients were treated with the various agents. A total of 79 patients received treatment with alkylating agents (nitrogen mustard and its related compounds) and of these there were 7 objective responses, somewhat less than 10 per cent. Among the agents giving response in one or more patients were chlorambucil (Leukeran®), Cytoxan®, and Thio-TEPA®.

Antimetabolites have also been used in renal cancer. Woodruff's review gave an over-all response rate of about 13 per cent. The agent most frequently studied among the antimetabolites was 5-Fluorouracil®, a pyrimidine antagonist. Of those patients treated with 5-FU alone, there were 5 objective responses in 36 patients with advanced renal carcinoma.

A variety of anti-tumor antibiotics have been tried in the past. Response rate to a variety of agents was less than 10 per cent in the aggregate.

The plant alkaloids Velban® (vinblastine) and Oncovin® (vincristine) have also been tried in renal cancer. There was only one responder among eight patients treated with vinblastine and no objective responses among twelve patients treated with vincristine.

Hormone therapy of advanced renal cancer was first recorded by Bloom and Wallace[2] in 1964. They reported on the use of testosterone and progestational therapy (Provera®). By the time of Woodruff's review[1] 24 patients with renal carcinoma had been treated with Provera® or testosterone. Of these there were five objective responses, four to Provera® and one to testosterone. The Provera® has been given orally at the dose of 100 milligrams daily or intramuscularly in dosages from 400 to 1000 milligrams weekly. In 1969, Talley *et al.*[3] reported two excellent objective regressions in a group of 16 patients treated with progestational agents. The author[4] has treated three other patients with metastatic renal cancer and observed one striking objective regression in the group. Bloom[5] feels that current best therapy in advanced renal malig-

* Read before the Joint Session of the Sections on Radiology and Urology, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 18, 1970, Dr. Koven is Assistant Professor of Medicine, and Director of the Oncology Division, New Jersey College of Medicine and Dentistry, Newark. A portion of this study was supported by National Cancer Institute grant, #T12 CA8135.

nancy is the use of high doses of progestational agents. If no objective improvement occurs within about eight weeks, or less if the patient is deteriorating, a change to testosterone proprionate is made.

Wilms' Tumor: Formerly one of the most lethal neoplasms in childhood, Wilms' tumor is now highly curable with a combination of surgery, radiation therapy and the antibiotic chemotherapy agent, dactinomycin (Actinomycin-D®, Cosmegen®). Ladd and Gross[6] reported cure rates of 32 per cent with surgery alone. Subsequently, with radiation therapy in combination with surgery, Gross and Neuhauser[7] reported a 47 per cent cure rate. The anti-tumor antibiotic dactinomycin has been of particular value in the treatment of Wilms' tumor. Farber[8] detailed laboratory evidence of a direct tumoricidal effect of this drug and, in addition, a radiosensitizing effect which augments radiation therapy. By combining surgery, radiation therapy, and dactinomycin survival rates of from 60 per cent to 90 per cent have been reported.[8, 9, 10] Various dosage regimens for the dactinomycin have been described. The Children's Cancer Study Group[11] reported on single versus multiple dose dactinomycin therapy of Wilms' tumor. They found 86 per cent (19 of 22) of their patients given maintenance chemotherapy had no recurrence compared to 48 per cent (11 of 23) without recurrence in the group given a single course of dactinomycin.

Bladder Cancer: Results of the use of systemic cancer chemotherapy in bladder cancer have been generally disappointing. Despite early favorable reports of the use of 5-Fluorouracil® in bladder cancer by Deren and Wilson[12] and Young,[13] a recent cooperative study by Prout *et al.*[14] demonstrated no advantage of the drug 5-Flourouracil® over placebo therapy.

On the other hand, chemotherapy has found a role in certain settings in early bladder cancer. Woodruff *et al.*[15] felt there was transient palliative benefit by combining 5-Flourouracil® with radiation therapy in advanced bladder cancer. Veenema[16] reported beneficial effects on bladder cancer by direct instillation of Thio-TEPA® in 1962. In his 1968 review, Veenema[17] gives the following indications for topical use of Thio-TEPA®: (1) Treatment of small, multiple, superficial, papillary tumors; and (2) Prophylaxis to minimize recurrence in those patients in whom there are patterns of multiple tumor recurrences. Veenema[17] outlines his current recommendations and method of use of Thio-TEPA® instillations in the 1968 article. He does not recommend Thio-TEPA® as treatment for invasive carcinoma of the bladder.

Seminoma: For pure seminoma, most authors recommend orchiectomy followed by radiotherapy to the periaortic and ipsolateral lymph nodes. In addition, when metastases are present in the abdomen, mediastinum and/or supraclavicular nodes, radiation therapy to these areas may be beneficial. Boctor *et al.*[18] reported a three-year survival rate of over 95 per cent in localized seminoma and a 60 per cent three-year survival rate when metastases were limited to the abdomen. Widely disseminated seminoma has been found to be responsive to the alkylating agent chlorambucil (Leukeran®). Mackenzie[19] recommends 10 milligrams per day by mouth until the appearance of leukopenia which usually takes from 4 to 8 weeks. Treatment is resumed when the white blood count returns to normal levels.

Other Testicular Cancers: Prior to the availability of modern chemotherapy, metastatic testicular cancer was almost invariably fatal. Following the dramatic remissions of metastatic trophoblastic tumors of the uterus in females, antimetabolites such as methotrexate, and DON® (6-diazo-5-oxo-L-norleucine) were tried with patients having testicular choriocarcinoma in pure or mixed forms. In contrast to the women, however, response of testicular tumor to these individual drugs was disap-

pointing. In 1960, Li *et al.*[20] reported regressions in 12 out of 23 patients with metastatic testis cancer treated with a combination of an alkylating agent, an antimetabolite, and the anti-tumor antibiotic Actinomycin-D®. In patients with choriocarcinoma, response was associated with a fall of chorionic gonadotrophin titres to negative value. Although there were intially some complete regressions, most of those patients subsequently relapsed.

More recently, Mackenzie[21] reviewed the results of chemotherapy of metastatic testis cancer in 154 patients. Of this total, 24 were rendered free of disease. In 21 of those 24 responders, Actinomycin-D® was used alone or in combination with chlorambucil or chlorambucil plus methotrexate. Mackenzie[21] concluded that the use of Actinomycin-D® alone is the most effective chemotherapeutic means of destroying metastases from embryonal carcinoma, teratocarcinoma and choriocarcinoma of the testis. Maintenance therapy with Actinomycin-D® is considered essential in those patients rendered clinically free of cancer.

Prostate Cancer: The role of estrogen therapy in advanced and metastatic prostate cancer is well known. Androgen control therapy was described by Huggins and Hodges[22] in 1941. Initial effect is seen in from 70 to 80 per cent of cases. Nesbit and Baum[23] reported a "pooled series" of prostate carcinoma patients treated with stilbestrol, orchiectomy, or a combination of both. They found that the combination of orchiectomy and stilbestrol seemed better than either stilbestrol or orchiectomy alone. However, in more recent years the practice of many urologists has been to use either orchiectomy or estrogen therapy alone rather than in combination. In addition, it is also felt appropriate by some authors to delay the onset of endocrine therapy in selected patients with prostatic cancer until symptomatic manifestations of the disease (either local extension or distant metastases) require its initiation. The Veterans Administration Cooperative Urologic Research Group[24] reported an increased incidence of cardiovascular complications with the administration of estrogens. The drug used was stilbestrol in 5 milligram daily doses. There did not seem to be an increased incidence of coronary artery atherosclerosis, but rather a problem with congestive heart failure. It may be speculated that had these patients been given close follow-up for their cardiac status the use of digitalis preparations and diuretics, there might have been a lower incidence of congestive heart failure. It is of interest that a new VA cooperative study[24] is underway with the use of a reduced dose of stilbestrol, namely one rather than 5 milligrams daily.

When advancing prostate cancer is no longer controlled by orchiectomy or the use of estrogens, additional symptomatic improvement may follow the use of corticosteroids. These responses are usually subjective, however, with regression of bone metastases usually not observed.

Non-hormonal chemotherapy has been almost universally unsuccessful in the past. At the present time, a new derivative of nitrogen mustard (aniline mustard) is being studied by Young.[25] Preliminary reports indicate an objective response rate of about 40 per cent. This drug is not yet generally available and should additional experience confirm the initial favorable results, it will be, indeed, a most valued addition for the management of patients with advanced prostate cancer.

Summary

Progestational agents seem to have a role in advanced renal cancer. Non-hormonal chemotherapy by and large has been rather ineffective. The addition of Actinomycin-D® to surgery and radiation therapy of Wilms' tumor has greatly enhanced the long-term survival rate. Bladder cancer in general remains quite refractory to chemotherapy. The exception

seems to be the use of Thio-TEPA® by local instillation for early superficial bladder cancers. Seminoma of the testis, when recurrent, may respond well to alkylating agent therapy with drugs such as chlorambucil. Other metastatic testicular tumors may respond to Actinomycin-)D® alone or in combination with chlorambucil and methotrexate. The responsiveness of prostate cancer to endocrine thearapy is well known. When androgen control methods no longer benefit the patient, additional symptomatic improvement may be produced by the use of corticosteroids. Preliminary reports regarding a new nitrogen mustard derivative useful in advanced prostate cancer will be watched with interest.

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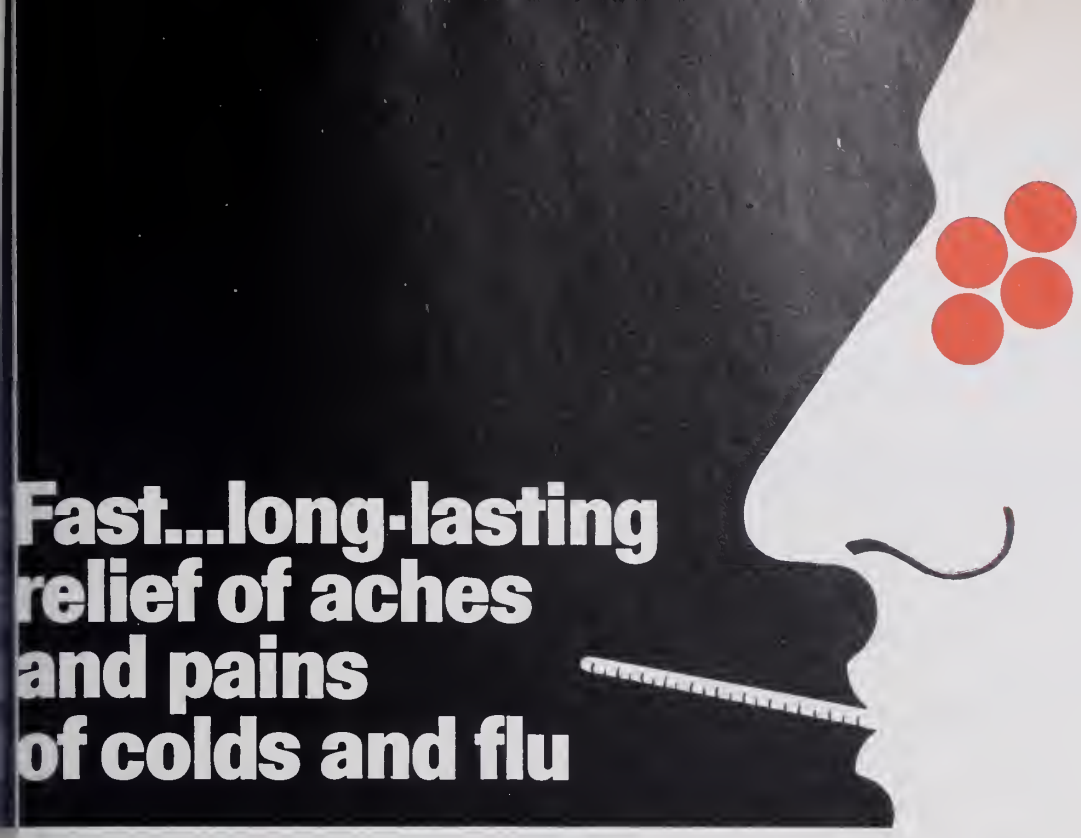
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148 Engle Street

New Arthritis Fact Book

Arthritis—the Basic Facts is a booklet that summarizes for the patient and the public what is known and what can be done about arthritis. It is published by the Arthritis Foundation to step up its campaign aimed at reducing the vast toll of disability caused by the nation's number one crippler.

The new booklet includes a section reporting recent progress in arthritis research. Acknowledgment is made of a grant to The Arthritis Foundation from the American Contract Bridge League Charity Foundation to help underwrite the publication costs of *Arthritis—the Basic Facts.* This generous underwriting has made a very large printing possible. Mass free distribution of the booklet to the public is planned by the local chapters of the Arthritis Foundation. Copies of *Arthritis—the Basic Facts* are available free from local chapters of The Arthritis Foundation or from the Foundation's National Headquarters, 1212 Avenue of the Americas, New York, N.Y. 10036.



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The Practitioner's Responsibility In Preventing Strokes*

Robert B. Weimann, M.D./Camden

During the past decade, the stroke patient has been treated as the derelict of the medical wards. Interns were sometimes instructed, in the accident wards, not to admit any stroke patients if at all possible. Once admitted, the patient usually was neglected. Treatment, when given, was usually just supportive. In 1958, a breakthrough came in the management of the stroke patient. Dr. Stanley Crawford devised an operation for removing blocks found at the origin of the internal carotid artery. It was felt that these blocks were the cause of most strokes. Correction of this underlying pathology was the beginning of a new era of treatment for these patients.

Relationship to Reestablished Blood Flow to the Over-all Results

Results	Number of Patients	Poor	%	Same	%	Improved	%
Average of Series	146	18	12.3	54	37.0	74	50.7
Average of Series Flow Not Reestablished	19	5	26.3	10	52.6	4	21.1
Average of Series with Flow Reestablished	127	13	10.2	45	35.5	69	54.3
Average of Mild or Prodromal Strokes	106	9	8.4	35	33.0	62	58.5

Combined Good Results of Mild or Prodromal Strokes is 91.6 Percent

Evaluation of results was divided into three categories: *Poor* meaning those cases who became worse from surgery; *Same* meaning those cases in which no change was noted or they were normal at the time of surgery; *Improved* meaning those cases which demonstrated improvement following surgery.

Over the past six years at Cooper Hospital (Camden, New Jersey) and Pennsylvania Hospital (Philadelphia) I have operated on 146 cases of carotid disease and have seen countless more in evaluation. I was the surgical participant of the "stroke team" started some years ago by Dr. Bascom Waugh. Results of this series compare favorably with those reported in the literature. There is an inherent risk to the operation, since the carotid circulation can be shut off for only a short period of time. In patients who have not developed a completed stroke and have just a mild or prodromal stroke, the risk has been just 8.4 per cent. However, untreated, these same patients carry a seventy to eighty percent chance of developing a stroke, many within one year.[2] This represents a tenfold risk to the patient if he does *not* have surgery. In my own personal series, not one person who has refused surgery has not developed a stroke, the majority occurring within five months.

What clues might aid the practitioner in suspecting the diagnosis and thus preventing a stroke? First, it takes an aware and curious physician. The early symptoms of cerebral vascular insufficiency can be very subtle. They may present only as spells of lighthead-

*Read before the Section on Medicine, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 18, 1970.

edness, dizziness, spots flashing across the eyes, recent change of vision, personality change, and mild mental deterioration. There may be episodes of numbness somewhere, and then, finally, of weakness. It is these patients we implore you to seek out and find, these are the ones who can be helped the most.

The patient who has developed a complete stroke now presents a different problem. Initially, Debakey[3] recommended immediate study and operation on these patients within eight hours. Vascular surgeons throughout the country (as well as is shown in this series) found that these patients did not fare too well. However, a few on whom I operated on within four hours, have immediately benefited. In general, this approach has been abandoned except for the progressing stroke. Here, emergency surgery is still indicated. Most strokes are allowed a "cooling off" period of two weeks of medical regime, during which time most of the studies are obtained. The decision is then made to operate either at that time or three months later. This more conservative approach has led to a better salvage rate of these more critical patients.

Physical examination might bring forth the first clue to a threatening situation long before the symptoms of cerebral vascular insufficiency ever develop. Take the time to listen at the carotid bifurcations in the neck just as you listen to the heart and you might then be appalled to hear a systolic bruit. These are the patients we are trying to find and evaluate arteriographically. This is preventive medicine. A bruit is almost pathogonomic of an underlying lesion. I have only seen two out of approximately one hundred and eighty to two hundred cases where the cause of the bruit could not be demonstrated on arteriogram. If a bruit cannot be heard ask the patient to hold his breath. Frequently a very soft bruit is audible by this maneuver. Bruits which are harsh and loud usually represent a high flow rate bruit. A very high pitched bruit usually means a small opening. A faint bruit may represent just a mild plaque or a life-threatening lesion.

Evaluation of these patients can best be done in a properly equipped center. Studies should include skull x-rays, EEG, brain scan (if available), spinal tap (if there is any suspicion of intracranial hemorrhage), and lastly, but most important, the arteriograms. Neurologic and vascular consultations are in order. X-rays usually demonstrate an obstructing lesion at the bifurcation of the common carotid artery or just extending up the internal carotid artery. They may demonstrate an inaccessible or intracranial lesion.

Surgery is naturally suited for lesions at the carotid bifurcation. Since this operation carries the risk of giving the patient a complete stroke, it is not the surgery for the novice. It should be done by a well experienced vascular surgeon. Otherwise, it probably carries a 30 per cent risk to the patient. At operation, heparin is injected into the artery. All the branches are clamped. Then the artery is opened and the plaque removed. A plastic shunt is inserted so that the circulation to the brain may be re-established. A Dacron patch is then sutured over the arteriotomy site. The shunt is removed before the last few sutures are inserted.

Post-operatively, these patients must be watched very closely. They must be followed for any signs of impending stroke, mental confusion, or lassitude. Monitor the blood pressure frequently and keep on intravenous fluids until the patient can take oral liquids. If the patient develops hypertension, this must be treated immediately; for he is then prone to have a cerebral hemorrhage. If cerebral edema occurs, this must be managed to prevent a complete stroke from developing. These patients are more susceptible to medications immediately post-operatively. Most medication or sedation must be given on one-half of the usual dosage scheduled. Fortunately, most of the patients do well and are discharged from the intensive care unit within forty-eight hours.

Most of these symptomatic patients who demonstrate pathology will shortly develop a stroke. This is true even of many of those

treated with anticoagulants. Realize that the risk of surgery is small compared to the risk of no surgery. Anticoagulants do not improve the flow to the brain but they do help prevent a cerebral thrombosis.

Reason for surgery is two fold. First, to prevent the eventual development of a stroke and second, to return the blood flow to the brain to normal. The hope is thus to continue these patients in a normally active and mentally alert life.

Summary

The most aggressive approach to the stroke problem is the attendance of an interested and curious practitioner who becomes suspicious by his history or physical findings. He refers his patient for diagnosis and investigation. This paper presents 146 cases of carotid surgery at a community hospital where the morbidity was 8.4 per cent in the mild or prodromal stroke patient. Encouragement is given to the physician to take a more aggressive approach to the handling of this disease.

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Prophylaxis Of Tinea Pedis

Efficacy of Tolnaftate Powder And Its Talc-Cornstarch Base

Benjamin B. Burrill, M.D.
and Alfred S. Nemlick, M.D./Montclair*

The prophylaxis of tinea pedis in a communal population is of particular interest because reinfection (or recrudescence) among susceptible individuals occurs readily in the absence of effective measures against the disease. English and her coworkers,[1] for example, showed that among 358 mentally retarded men in a long-stay hospital in Bristol, England, the incidence of tinea pedis‡ and tinea unguium was 41 per cent.

At the request of Schering Corporation, we evaluated a tolnaftate powder in the prophylaxis of tinea pedis in a communal hospital population. The therapeutic efficacy of the drug in treatment of superficial fungal infections had been established previously.[2,3]

Before treatment, the ambulatory, adult male patients on two wards in an extended-care, psychiatric hospital in New Jersey were studied to establish the baseline incidence of tinea pedis in these patients at the beginning of the summer of 1968. The patients on one ward were then treated for 8 to 12 weeks with Tinactin® Powder, a talc-cornstarch powder containing tolnaftate 1 per cent. Those on the other ward were treated concurrently with the talc-cornstarch base only. During weeks 8 through 12, the patients were reexamined. Treatment and post-treatment phases of this study were conducted under double-blind procedures.

Although random selection of patients to be treated from both wards might have been statistically preferable, it was not practicable because the vehicle-treated patients would have come into contact with small but therapeutic amounts of tolnaftate from the attendants and tolnaftate-treated patients. The possibility of treatment error, moreover, would have been increased.

Pretreatment Examination

The patients' dermatologic history was recorded and over a period of four weeks their feet were examined personally by the senior authors for the lesions of tinea pedis or tinea unguium. If signs of either were present, scrapings from the lesions were cleared with potassium hydroxide and examined microscopically. The scrapings were also cultured on Sabouraud's agar. If the results of either or both laboratory tests were positive, the patient was classified as having clinical and laboratory evidence of tinea pedis or tinea unguium. Primary attention was given to data on tinea pedis. Clinical and laboratory evidence were evaluated separately because their correlation in studies reported previously has varied among different populations.[4,5]

One ward proved to have a higher incidence of infection than the other. This ward had shower rooms that were considerably smaller, dirtier, and wetter than those on the other ward. To realize the number of patients with

* With the assistance of John A. Leer, Jr., M.D. and Joel I. Levine, M.D., Schering Corporation, Bloomfield. This study was conducted at the Essex County Overbrook Hospital, Cedar Grove (NJ), during the summer and fall of 1968.

‡ The term *tinea pedis* in this paper is reserved for superficial fungal infection of the skin of the feet. Fungal infection of the toenails is specified as *tinea unguium*.

laboratory-confirmed tinea pedis on the wards, some patients who had tinea pedis on the higher-incidence ward were exchanged with an equal number of patients (without tinea pedis) from the lower-incidence ward. With the patient population thus balanced (Table 1), treatment with one per cent tolnaftate powder or its talc-cornstarch base was started.

Table 1
Results of Pretreatment Examinations

WARD A

Patients without tineal lesions	Patients with tineal lesions	
	positive*	13
	negative*	9
45		22

WARD B

Patients without tineal lesions	Patients with tineal lesions	
	positive	12
	negative	3
41		15

* Results of KOH Test or culture.

Treatment Period

Tolnaftate powder 1 per cent was used on the ward that initially had had the higher incidence of tinea pedis, while the powder base alone was used on the other ward. Specially assigned ward attendants dusted one powder or the other between the toes and on the dorsa and soles of the patients' feet, twice daily, Monday through Friday, for eight weeks. Double-blind procedures were observed.

All treatments plus any comments of possible medical significance were recorded in a log book kept for each patient by the attendants. This log book was reviewed by the study monitor (Levine) at least once every two weeks.

Excluded from the final data tabulations were results in patients who were *not* treated for five successive treatment days at any time during the study. Also excluded were results in those who received less than 75 per cent of the total number of treatments administered.

Post-Treatment Examination

After eight weeks of treatment, the investigators re-examined the patients' feet. Potassium hydroxide preparations and cultures of skin scrapings were made again if lesions were visible. These examinations extended over four weeks, an equal number of patients from both wards being examined at a time. During this four-week period, the twice-daily powdering of the patients' feet continued. On the morning of their re-examination, however, the patients were not treated. Their feet were washed with soap and water and dried with paper towels to remove medication that might interfere with fungiculture.

Results

Of the 218 patients who participated in this study, 123 completed the prescribed treatment, satisfying the requirements of the protocol. Of these, 86 did not have tinea pedis before treatment, and 37 did. Results in the 86 patients were evaluated for the comparative prophylactic efficacy of one per cent tolnaftate powder. Results in the other 37 patients were evaluated for the therapeutic efficacy of the preparations.

Of the 86 patients who did not have tinea pedis before treatment, 45 were treated with one per cent tolnaftate powder, while 41 were treated with the talc-cornstarch base. In 39 of the 45 patients treated with tolnaftate powder, there was no clinical evidence of tinea pedis. Six of these 45 had tineal lesions, but dermatophytes were not detected in skin scrapings from any of the six. By contrast, there was no clinical evidence of tinea pedis in 20 of the 41 patients treated with the talc-cornstarch base. The other 21 of these 41 patients had tineal lesions, and dermatophytes were present in 16 of the 21 (Table 2).

Analysis of the data on prophylaxis by Fisher's Exact Probability Test indicated that the ratio of patients without tineal lesions *after* treatment to those without tineal lesions *before* treatment is significantly higher ($p < 0.001$) in the group of patients treated with one per cent tolnaftate powder than in those treated

with its talc-cornstarch base.

In the 37 patients who had tinea pedis before treatment, 18 of 22 who were treated with one per cent tolnaftate powder had *no* signs of the disease at the end of the study, whereas 9 of the 15 treated with the talc-cornstarch base had tineal lesions (Table 2).

Table 2
Results of Post-Treatment Examinations

WARD A

67 patients treated with tolnaftate powder 1%

	Results in the 41 patients without lesions before treatment	Results in the pts. with lesions before treatment	
		Laboratory positive* (13 pts.)	Laboratory negative* (9 pts.)
Pts. without lesions after treatment	39	10	8
Pts. with lesions after treatment	6	3 (1*, 2)	1*

WARD B

56 patients treated with talc-cornstarch

	Results in the 41 patients without-lesions before treatment	Results in the pts. with lesions before treatment	
		Laboratory positive (12 pts.)	Laboratory negative (3 pts.)
Pts. without lesions after treatment	20	6	0
Pts. with lesions after treatment	21 (16*)	6*	3*

* Results of KOH Test or culture, or both.

Discussion

The data indicate that, in patients who had no tineal lesions initially, tinea pedis developed in significantly fewer of those treated with one per cent tolnaftate powder than those treated with its talc-cornstarch base. These data on prophylaxis are supported by two other findings that served as internal controls in the study. One was that the number of tolnaftate-treated patients who were cleared of tinea pedis was high (18 of 22) compared with those cleared by talc-cornstarch (6 of 15). Also, in a concomitant observation of tinea unguium in these patients, little therapeutic benefit was evident, and results with one per cent tolnaftate powder and talc-cornstarch did not differ. These results were expected: Tolnaftate is effective in superficial fungal infection but not in lesions in hard keratin.[3]

The data also suggest that a simple foot powder (talc-cornstarch) is inadequate for prophylaxis of tinea pedis. This hypothesis remains to be demonstrated, however, in comparative studies that include a group of patients not treated at all.

Conclusion

The results of this comparative study indicate that tolnaftate was effective in the prophylaxis of tinea pedis in the male patients on a ward in an extended-care psychiatric hospital, and is therefore a promising compound for further study in the prophylaxis of tinea pedis. The results also confirm previous reports of the therapeutic efficacy of tolnaftate in tinea pedis.

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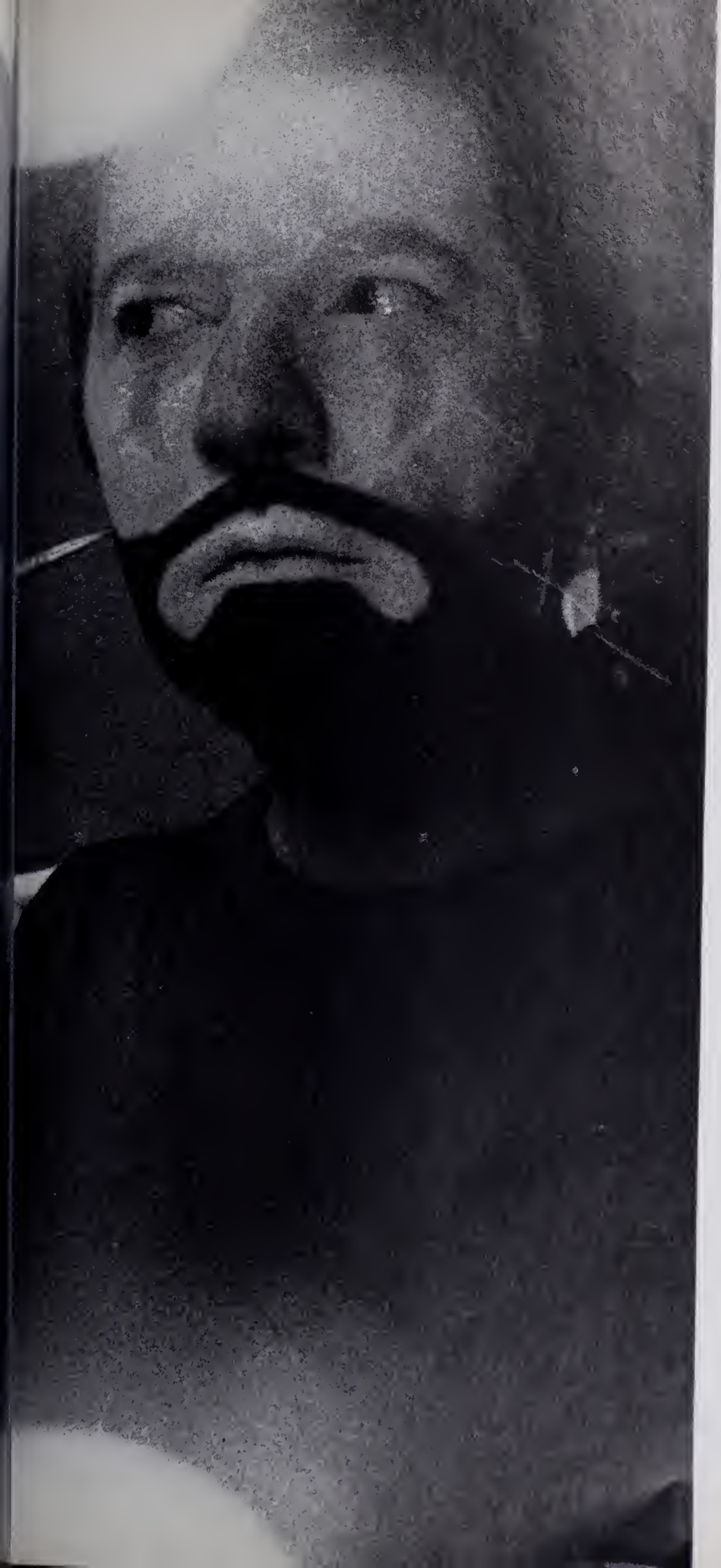
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Not all that convulses is epilepsy. Dr. Revitch here suggests some practical differential pointers.

Epileptic And Non-Epileptic Paroxysms:*

A Problem Of Differential Diagnosis

Eugene Revitch, M.D./Plainfield

In connection with a legal action a few years ago, New Jersey physicians were dismayed by the discovery of a 1912 law which required the reporting of epileptic patients to boards of health. This precipitated a rush of reports not only of cases with seizures but also of patients with paroxysmal manifestations of non-epileptic origin. For this reason a review of the concept and diagnosis of epilepsy and of non-epileptic paroxysms seems to be timely.

The Jacksonian concept of an epileptic seizure as being a clinical correlate of an excessive neuronal discharge is now widely accepted. The difference between an epileptic and non-epileptic paroxysm is simply the presence (or absence) of an excessive electrical discharge in the brain. Non-epileptic paroxysms are an expression of emotional release through motor activity or of perceptual and somatic concomitants of anxiety. In addition there are attacks (chiefly of organic nature or remotely connected with emotions) such as hypoglycemia, narcolepsy (particularly attacks of cataplexy), migraine, and fainting spells that should be considered in the differential diagnosis.

Diagnostic Problems

Paroxysmality and alterations of consciousness are the cardinal symptoms of epilepsy. Unless the clinical picture is classical and clear-cut, this may be insufficient for a definitive diagnosis. There is an array of bizarre psychogenic seizures resembling grand mal. Minor and psychic attacks may present a difficult and at times insoluble problem of differential diagnosis. Emotional precipitation of these attacks can be usually elicited with meticulous psychiatric investigation, but even this is not assurance that the seizures are non-epileptic. Many epileptic seizures may be emotionally precipitated.[1] There is a whole spectrum of bizarre epileptic seizures with various degrees of emotional and organic components.[2] The diagnostic difficulties in cases involving psychologic functions were stressed by Williams.[3] Electroencephalography is an invaluable adjunct to our diagnostic armamentarium, but it is not always helpful and at times it may be confusing. The reason for these failures is as follows: (a) an abnormal discharge may be recorded with depth electrodes only (essentially a neurosurgical or an experimental procedure); (b) routine record may be normal while activating procedures such as induced sleep, intravenous injection of metrazol, or photic stimulation may elicit a focal or generalized abnormality; (c) artefacts and technical errors may be misread as abnormal discharges; (d) abnormal records in non-epileptics may be associated with non-epileptic motor or psychic paroxysms.[4,5,6] Furthermore, the boundaries of epilepsy are not always clear. Thus, the 6 and 14 per second positive spikes described by Gibbs and Gibbs[7] as associated with behavioral and autonomic outbursts were thought to be diagnostic of what they named thalamic and hypothalamic epilepsy. Subsequently it was found that this EEG pattern may be familial and may be seen

* This work is from the New Jersey State Diagnostic Center, Menlo Park, N.J.

in adolescents without the clinical picture described by Gibbs. Consequently many doubts were expressed as to the epileptic nature of the entity. Henry[8] states that "the real clinical significance of this pattern, if there be any, is anything but clear." His experience suggests that "bursts of positive spiking might be regarded as a neurophysiologic handicap, the importance of which varies as function of the environment." Schwade and Geiger[9] also criticized the "epileptic" theory of this pattern and they felt that the attacks were due to rhinencephalic release phenomena, i.e. they were emotional outbursts due to poor physiologic control mechanisms. Neurologic examination, spinal fluid, and contrast studies rarely enlighten the practitioner, unless the seizures are due to a space occupying mass. In some psychoanalytic and psychologic circles epilepsy is considered to be a specific entity with specific personality make-up which can be elicited with projective tests. Lennox[1] and most epileptologists believe this to be untrue. Of all the diagnostic steps, a thorough history with a scrupulous recording of the seizures is the most important. Presence of an aura or of initial motor phenomena (such as adversive movements or Jacksonian march) related to a specific focus of discharge, indicate, without fail, the epileptic origin of a seizure. The diagnosis of complex psychiatrically tinged seizures is impossible without a thorough knowledge of brain anatomy. This knowledge enables the clinician to deduce the initiation and spread of the discharge in the brain through observable clinical manifestations. Such an anatomoclinical correlation, wherever it can be established, is the most certain diagnostic criterion. The following case may serve as illustration:

Case 1—A 32 year old male had attacks of falling down, rolling on the floor, thrashing around, and fighting those who approached him. EEGs were normal. The attacks seemed to be of emotional rather than epileptic nature. At a later date, a thorough anamnesis elicited epigastric sensations and visual hallucinations preceding the attack.

This type of aura corresponds to a discharge starting in the sylvian fissure and spreading to the temporal area. In fact an abnormal record (anterior temporal spike) was recorded in light sleep, but this followed the diagnosis established through clinical means. Lennox,[1] in a discussion from the floor at one of the meetings, stressed the frequent diagnostic uncertainties and the necessity of prolonged observation in complex and bizarre seizures.

Non-Epileptic Attacks

Cases of non-epileptic attacks and their diagnostic problems were recently reported by Liske, *et al.*[10] and Ferris.[11] These authors however did not make an attempt at classification and Ferris[11] just mentions that the attacks "are of a type often called hysterical seizures." That not all of the non-epileptic seizures are "hysterical" was stressed by Guillain.[12] He described under the name of "crises neuropathiques" attacks which are neither hysterical nor epileptic. The authors at the turn of the century questioned the possibility of seizures intermediate between epilepsy and hysteria and they coined the phrase "hystero-epilepsy." The concept of intermediate seizures is still supported by some French authors.[5] A mixture of epileptic and non-epileptic seizures in the same patient is a distinct possibility. In Monroe's 20 cases of non-epileptic attacks with predominantly psychiatric symptomatology, nine had occasional grand mal and psychomotor seizures.[13] In previous papers[5,6] I divided the non-epileptic seizures into (a) catathymic attacks, (b) short episodes of distractibility and inattention, and (c) episodes of perceptual alterations. To this, one should add true hysterical attacks. Attacks are considered hysterical when they solve an inner conflict symbolically through motor activity. The *grande hysterie* of Charcot is a typical example. In these cases the seizures may be prolonged and manifested by bizarre motility or by rigid postures, usually opisthotonos. The following case is representative:

Case 2—A 15 year old boy had attacks of opisthotonos lasting 45 to 60 minutes. Prior to a seizure, he rushed to the school nurse, but never could reach her office in time because of loss of control of his legs. Spells were preceded by sharp pain in the chest. During the spell, breathing was noisy and rapid; or at times he seemed to hold his breath and choke. He usually grunted and groaned and after the spell he staggered around the office for several minutes. His physician felt he needed

immediate hospitalization to prevent "status epilepticus." In the course of therapy it was discovered that seizures were preceded by arguments with mother. The patient was a strange, suspicious, and secretive boy. He had a particular attraction for reptiles and on one occasion he brought a valise with snakes to my office and let the snakes crawl on my desk. His seizures stopped later in life when he left home.

Catathymic attacks are referred to in the French literature.[5] They consist of behavioral outbursts considered neither hysterical nor epileptic. In most cases, the attacks present a diffuse uncontrolled and undirected expression of underlying rage. In many instances the attacks are preceded by a traumatic event. Emotional instability and outbursts of anger with assaultiveness and destructiveness are a common finding. A typical example are cases of delinquent girls tearing off the radiator, cutting the breast with a piece of glass, or thrashing on the floor. I had the opportunity to examine such cases in correctional institutions. When the attacks seem to be unprovoked and patients allege amnesia following recovery, the differential diagnosis with psychomotor epilepsy is an obvious problem. Careful interview particularly under the influence of intravenously injected sodium Amytal® or in superficial stages of hypnosis, usually brings forth the emotional stimuli precipitating the attack. These attacks improve with maturation and with motivation. The following case is illustrative:

Case 3—A young adult male prisoner serving a sentence for breaking and entering had frequent attacks of violence preceded by pulsating bitemporal headache. This was followed by buzzing in the ears, tension, sweating, and a feeling he had to destroy everything in his path. The attacks occurred mostly in crowds or when he felt trapped or enclosed. He had a history of emotional instability, inner tension, frequent outbursts of anger and homicidal impulses. He said, "I always wanted to kill. When I go down in the yard and somebody looks at me I want to choke him." The Rorschach protocol reported aggressiveness and violence. His attacks were blind rages with poor recollection of the incidents. He improved with tranquilization and psychotherapeutic interviews. EEG was normal.

Short episodes of inattention may pose the differential diagnosis with petit mal and temporal lobe epilepsies. I found these phenomena mostly in children with distractibility, inattentiveness, and introversion.[6] One of these children, when first seen at the age of 10 was diagnosed elsewhere as a case of petit mal. His EEG however never showed the typical petit mal pattern, the attacks lasted ten or more minutes, particularly when he was bored in school, and finally stopped in late adolescence.

Short episodes of perceptual alterations are not uncommon in anxious and depressed individuals. The most commonly encountered manifestations are episodic feelings of unreality and derealization. The patient may feel unreal, distant, or in a fog. Others may present visual or kinesthetic illusions particularly in states of reduced vigilance. Any stimulus arousing vigilance abolishes the sensations. The experience consists in attacks of macropsia, autoscopy, and changes of body size. The most common kinesthetic illusion I had the opportunity to observe was a feeling of acceleration of body functions and of the passing time. All of these phenomena may be seizure manifestations in temporal lobe epilepsies, may be part of the migraine syndrome, or may be seen in psychiatric conditions.

Case 4—A 15 year old boy had attacks of "strangeness and unreality" lasting 15 to 20 minutes. They were precipitated by rapid changes in the environment or through concentration. The boy was sensitive, introverted, anxious, and phobic. EEG was normal.

Cases 5 and 6—A sensitive, introverted 11 year old girl and an albino 13 year old boy had attacks so similar in appearance that both are reported together. Both, when reading or alone in a quiet room, experienced a feeling of extreme acceleration of their movements, of body functions and of the passage of time. This could be interrupted through turning on the radio, joining the family in another room, or through stimulating activity. The episodes were accompanied by anxiety and both children were relieved with reassurance.

Comment

The area of differential diagnosis between epilepsy and non-epileptic paroxysms belie the spreading notion that psychiatry and neurology should be absolutely separated, and that the practice of psychiatry should follow a sociologic rather than medical model. It also confirms the value of the clinical approach and of neuropsychiatric rather than purely psychiatric or purely neurologic perspective. Cushing[14] expressed the importance of clinical orientation in the following words: "We have instruments of precision in increas-

ing numbers with which we and our hospital assistants at untold expense make tests and take observations. The vast majority of these are but supplementary to and as nothing compared with the careful study of the patient by a keen observer using his eyes and ears and fingers and a few simple aids." In many instances of bizarre seizures, only cumulative evidence of a prolonged clinical follow-up leads to a final diagnostic formulation. Case One is an example of such eventuality. Postictal sleepiness and headaches and seizures occurring at night, particularly in the early hours of the morning upon awakening, are some other clues favoring an epileptic diagnosis. The complex seizures are not always easy to diagnose and therefore it is suggested that unqualified, precipitous reporting of patients with paroxysmal symptomatology is unwarranted.

Summary

Epilepsy was defined in Jacksonian terms as a clinical manifestation of excessive neuronal discharge. The non-epileptic paroxysms may present pure emotional discharges or conditions such as cataplectic attacks of narcolepsy, manifestations of hypoglycemia, or various types of fainting spells due to emotional, vascular, or cardiac causes. The importance of clinical orientation and of the neuropsychiatric, rather than purely psychiatric or purely neurologic perspective, for successful diagnosis of ambiguous cases was stressed. It was suggested not to report patients as epileptics just because of paroxysmal nature of their condition.

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Parents who are concerned that their children may get caught up in the rapidly spreading use of drugs need to be more sensitive to the danger signs and more knowledgeable about drugs themselves.

Drug Abuse And Your Child by Alice Shiller, a new Public Affairs pamphlet, discusses some of the reasons young people turn to drugs; alerts parents to signs of drug abuse; summarizes basic information about drugs; and suggests what can be done to prevent drug use and to help a child get off drugs. *Drug Abuse and Your Child* is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, New York 10016

Special Article

A New Telephone Tape Information Service

The following item comes from the New Jersey Regional Medical Program, Alvin A. Florin, M.D., Coordinator, and James P. Harkness, Ph.D., Deputy Coordinator.

Ready physician access to the latest information on the detection and treatment of disease is a goal of the New Jersey Regional Medical Program. RMP's have been experimenting with methods of reaching the practicing physician, with 88 projects operating throughout the country. Specific technics range from the established method of formal courses to innovations such as telephone dial access taped presentations. Educational subjects vary from specific clinical topics to medical administration as each program attempts to meet the educational and information needs and interests of its physicians.

In the summer of 1968, the New Jersey Regional Medical Program staff interviewed a state-wide sample of physicians to determine their requirements for continuing education, and how these requirements related to private practice. Many physicians expressed interest in the availability of short presentations devoted to single topics and made easily accessible 24 hours a day by telephone. Such a program had been inaugurated by the Regional Medical Program in Wisconsin with considerable success. It was decided, therefore, to develop a service in New Jersey with 4 to 6 minute taped subjects written by New Jersey physicians, and made available on a toll free basis twenty-four hours a day.

In October, 1968, a library of 74 tapes was announced in a brochure mailed to each physician in the state. Physicians can request an operator to play one or more tapes of their choice by dialing (201) 375-2525.

The first series of tapes was based upon recommendations of members of heart disease, cancer, and stroke task forces of the New Jersey Regional Medical Program. To date, 37 New Jersey physicians representing the medical staffs of one hundred hospitals have authored 61 medical tapes. The balance of the library is made up of tapes obtained from the Wisconsin Regional Medical Program.

In the first twelve months of operation 3,418 calls were received. The first five weeks following the inauguration of service saw a great deal of interest with calls averaging 250 per week. The number rapidly decreased to only one or two calls per day. A second brochure announcing the updating of available subjects was mailed in the fortieth week of service whereupon the number of calls rose again to 200 per week. This parallels the experience of the Wisconsin program.

The fact that over 200 physician calls were received immediately following the mailing of the second brochure, prompted the staff to study all aspects of the program in order to design a service for maximum usefulness and convenience.

Reports from the answering service were tabulated. The staff designed and distributed a questionnaire together with a brochure on the tape program mailed to all physicians. One hundred and ninety-one physicians returned the questionnaires including 116 specialists, 54 general practitioners, and 21 osteopathic physicians. Over two-thirds of the respondents stated they had used the service. Of these: 87 per cent found the service useful. 5 per cent found it not useful, and 8 per cent had no opinion.

A summary of results from questionnaires and utilization reports from answering service follows:

I. *Subject Matter*—Physicians were asked what subject areas of the tape library should be expanded. High interest was expressed in new topics for heart and related diseases, es-

pecially in general advances in medicine. It would also appear that many physicians were interested in new subjects in all disease areas mentioned.

Table 1

Frequency of physician responses to the question, "What areas of the program should be expanded?"

	Diagnosis	Treatment	New Drugs	General Advances in Medicine
Heart Disease	45	55	58	64
Cancer	37	40	49	53
Stroke	29	38	35	42
Related Diseases	50	49	49	57

II. *Hours of Service* — The distribution of calls among the morning, afternoon, and evening hours means that the service meets the needs of physicians for an easily accessible, educational information service.

Table 2

Time Periods During Which Calls Were Received October 1, 1968-September 30, 1969

Hours	Number	Per cent
6:00 a.m. to noon	763	22
Noon to 6:00 p.m.	1,318	39
6:00 p.m. to midnight	1,180	35
Midnight to 6:00 a.m.	157	4
Total	3,418	100%

Although the service is not specifically designed to supply information for medical emergencies, the 157 calls received during the late night and early morning hours may indicate a need on the part of some physicians for emergency information. A look at the tapes requested between midnight and 6:00 a.m. shows that 50 of the 157 were on emergency subjects. These included cardiac arrest; toxicity and side effects of anti-arrhythmic drugs; immediate care of acute stroke; acute hypertensive crisis; acute pulmonary edema; heart block and pacemaker; angina pectoris; and cardiac arrhythmias.

This indicates that the service may have potential for providing information to physicians that can be applied in the diagnosis and treatment of emergency conditions.

III. *Medical Specialty Interest*—When a physician calls to request a tape, the answering service operator asks his specialty and location of practice. A tally of calls revealed that 54 per cent of the physicians were in general practice.

IV. *Geographic Distribution of Calls* — Requests have been received from every county in the state. Of the 3,229 calls received, 2,603 (80 per cent) were in the 201 code area which includes the northern and central sections of the state.

Table 3

Number of Calls by County (One year period)

Atlantic—85	Middlesex—238
Bergen—458	Monmouth—240
Burlington—58	Morris—229
Camden—212	Ocean—68
Cape May—18	Passaic—200
Cumberland—27	Salem—15
Essex—478	Somerset—72
Gloucester—70	Sussex—34
Hudson—211	Union—334
Hunterdon—27	Warren—14
Mercer—132	Entire State—3229

NJRMP staff continually evaluates physician satisfaction with the quality, content, and availability of the tape service. Methods used to date include:

—Tear-out evaluation sheets on mailed brochures.
—Randomly spaced telephone inquiries to physicians soliciting opinions on particular topics.
—Review of and consultation with other RMP telephone tape services across the country.
—Review of current topics by medical school specialists and state and local medical societies.

Suggestions for improving the service have led to the following developments:

—A new easier to remember telephone number, *D*ial *P*hysicians *L*ine—2525.
—Index tapes in heart disease, cancer, stroke and related diseases. By calling the service and asking for the index tape in heart disease, for example, physicians will hear a list of available heart disease subjects. The operator remains on the line to fill the physician's request.
—The addition of 109 tapes for a total of 153 subjects with new subjects broadening the scope of the service.
—Regular mailing of brochures updating available tape topics with additional copies distributed to hospitals for physicians' mail boxes.
—A new library of tapes for nurses now available.

The New Jersey Regional Medical Program staff is always ready to receive suggestions and physicians are encouraged to contact this office at 7 Glenwood Avenue, East Orange 07017. If you have misplaced your catalogue listing the tapes, write or call for another copy.

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see 5 or more problem drinkers in 2-month period	34.7	37.1
half or more seen are women	41.8	37.4
treat, rather than refer	73.1	72.6
more community services needed	65.0	63.0

*based on preliminary data supplied by Center of Alcohol Studies, Rutgers Univ. †absolute alcohol

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Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychoneuratic Manifestations: Serentil reduces the symptoms of anxiety and tension, prevalent symptoms often associated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

Attention should be paid to the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related to Serentil, one should be aware that such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection.

Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of a few (rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found among those patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos) have been reported.

Autonomic Nervous System: Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiovascular System: Hypotension and tachycardia have been reported. EKG changes have occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the following have occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autonomic Reactions: Miosis, obstipation, anorexia, paralytic ileus.

Cutaneous Reactions: Erythema, exfoliative dermatitis, contact dermatitis.

Blood Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edema, asthma.

Hepatotoxicity: Jaundice, biliary stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed in some patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarization and not related to myocardial damage. They appear to be reversible. There is no evidence at present that these chang are in any way precursors of any significant turbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arr has been noted.

Extrapyramidal Symptoms: Akathisia, agitati motor restlessness, dystonic reactions, trism torticollis, opisthotonos, oculogyric crises, tren muscular rigidity, akinesia—some of which rare occasions have persisted for several mon or years especially in patients of advanced a with brain damage.

Endocrine Disturbances: Menstrual irregularit altered libido, gynecomastia, weight gain. Fa positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects sugg tive of a paradoxical reaction have been report These include excitement, bizarre dreams, agg vation of psychoses and toxic confusional stat More recently, a peculiar skin-eye syndrome h been recognized as a side effect following lo term treatment with phenothiazines. This reacti is marked by progressive pigmentation of are of the skin or conjunctiva and/or accompanied discoloration of the exposed sclera and corn Opacities of the anterior lens and cornea scribed as irregular or stellate in shape ha also been reported.

DOSAGE AND ADMINISTRATION: Oral: The d age of Serentil (mesoridazine), as in most me cations, should be adjusted to the needs of t individual. The lowest effective dosage shou always be used. When maximum response achieved, dosage may be reduced gradually a maintenance level.

Alcoholism: For most patients the usual starti dose is 25 mg. b.i.d. The usual optimum tot daily dose range is 50-200 mg. per day.

Schizophrenia: For most patients, regardless severity, a starting dose of 50 mg. t.i.d. is reco mended. The usual optimum total daily dose rang is 100-400 mg. per day.

Behavioral Problems in Mental Deficiency a Chronic Brain Syndrome: For most patients a sta ing dose of 25 mg. t.i.d. is recommended. Th usual optimum total daily dose range is 75-300 m per day.

Psychoneurotic Manifestations: For most patients th usual starting dose is 10 mg. t.i.d. The usual op mum total daily dose range is 30-150 mg. per da

Injectable Form: In those situations in which a intramuscular form of medication is indicate Serentil (mesoridazine) Injectable is available. Fo most patients a starting dose of 25 mg. is reco mended. The dose may be repeated in 30 to 6 minutes, if necessary. The usual optimum total dai dose range is 25-200 mg. per day.

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NEW JERSEY DOCTORS' NOTEBOOK

News From NJCMD

Inability to comprehend the printed word properly constitutes a grave handicap (culturally, socially, and economically) in our complex society. Reading and learning disabilities are present in up to 30 per cent of the total school population (as high as 80 per cent in certain areas). Some of these are dyslexias. Originally this term was used to describe a specific neurologic dysfunction involving the inability to interpret the written or printed symbol. However, the word has taken on the wider meaning of learning or reading disability in a person of normal or even superior intelligence.

Perhaps better called "reading retardation," dyslexia is now, unfortunately, at the mercy of a battle of semantics between advocates of differing approaches. This has been recognized by The Medical Society of New Jersey, which has issued a special policy statement on dyslexia through its Committee on Emotional Disorders of Childhood and Adolescence.

Because of the distressing nature of the problem, many parents, educators, and therapists may despairingly grasp any seemingly rational, simplistic solution offered as treatment despite its dubious validity.

No one basic cause for dyslexia exists. Etiologic factors include environmental ones, such as cultural or economic deprivation, family environment, emotional problems, overcrowded classrooms, inadequate or faulty teaching. Other factors are physical such as poor health, malnutrition, fatigue, neurologic impairments, congenital or acquired cerebral damage, ocular and auditory dysfunctions, hereditary factors. If treatment is started in the 1st or 2nd grade, 80 per cent of the children should be able to reach normal academic achievement. If started in the 6th grade or above, only perhaps 15 per cent can achieve normal academic level.

When Johnny can't read (and Johnny is involved more often than Suzie) a meticulous physical and psychological examination should be performed. Evaluation and treatment involves a multi-discipline team including the family doctor, the educator, a neurologist, an ophthalmologist, an otolaryngologist, a pediatrician, a psychiatrist, a psychologist, a school nurse, a school social worker, and the school doctor. Compensatory educational technics must be used where causative factors cannot be neutralized by treatment. Each child needs a flexible therapeutic and pedagogic program tailor-made for his particular needs. No single system of therapy, however plausible it may seem, can be rationally offered as a "cure" for a disorder whose causes are so varied and complex.

The ophthalmologist is often among the first consulted when a child has difficulty reading. Ocular disorders rarely play a primary role in learning disabilities, although they may, in a number of cases, have a secondary role in decreasing visual efficiency so that resultant fatigue renders it difficult to maintain the effort required in pursuing the necessary tasks. The ophthalmologist is expected to evaluate existing ocular disorders and to help the individual attain the most effective, efficient vision possible with corrective lenses or other optical devices or where indicated, by drugs, exercises, or surgery. He plays an equally important role in counseling the patient and parents, communicating with the educator, and helping to ensure that the necessary multi-disciplined evaluation is carried out.

Not enough objective scientific evidence yet exists to prove that perceptual motor training of the visual system can significantly influence reading disability. In coping with dyslexia, ophthalmologists should be involved in an

interdisciplinary approach. Eye care should never be handled in isolation when the patient has been referred with a reading problem. The belief that eye dominance can be at the root of so profound and broad a human problem as reading and learning disability is naive, simplistic, and unsupported by scientific data.

Latent strabismus may be associated with a reading disability in some children. This may be treated according to the doctor's own ophthalmologic principles, but it is significant to the learning problem only in improving reading "comfort or efficiency." Eye glasses, including bifocals, prescribed specifically for the treatment of dyslexia have not proved effective.

Just how children with reading disabilities should be taught is a technical problem in educational science. Children with reading disabilities, once diagnosed, probably should be removed from the milieu where conventional methods of teaching are practiced, in order to give them special instruction along totally different lines.

Other states have been active in numerous approaches to dyslexia. There have been periodic and fragmented studies of the subject in New Jersey, but no coordination or continuing program. In view of the differing approaches and the complications involved, we at NJCMD are anxious to encourage such an ongoing, coordinated study of dyslexia.

To that end, we hope some of the questions about dyslexia will be covered in a special symposium to be offered November 4, 1970 at the clinical seminar sponsored by the New Jersey Academy of Ophthalmology and Otolaryngology in conjunction with NJCMD's Division of Ophthalmology, the Eye and Ear Infirmary Unit of Newark's United Hospitals, and the New Jersey Commission for the Blind. The Dyslexia Symposium will occupy the afternoon commencing at two o'clock at Newark's Robert Treat Hotel at Military Park (where there is underground parking directly connected to the hotel).

The program is under the direction of Dr. Anthony Sellitto, Assistant Clinical Professor at NJCMD, and Chief of Ophthalmology at Newark Eye and Ear Infirmary. A panel of speakers has been assembled to approach dyslexia from the viewpoint of a number of disciplines and specialties.

Further information on the Seminar, and inquiries for reservations should be directed to: Miss Margaret Parella, Secretary, New Jersey Academy of Ophthalmology and Otolaryngology, c/o NJCMD, 100 Bergen Street, Newark, N.J. 07103. We hope to see you there.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

FAMILY PRACTICE—Joseph P. Chollak, Jr., M.D., 132 South Franklin Street, Wilkes-Barre, Pennsylvania 18702. Jefferson 1967. Group. Available, August 1971.

OBSTETRICS AND GYNECOLOGY—Roland F. Fleck, M.D., 1061 Nash Avenue, Lansdale, Pennsylvania 19446. Jefferson 1961. Board eligible. Partnership, group, industrial. Available.

Osmundo N. Saguil, M.D., 3328-B Avery Drive, Fort McClellan, Alabama 36201. University of Santo Tomas, Philippines 1961. Board eligible. Partnership. Available January 1971.

Ira Bernstein, M.D., 660 East 98th Street, Brooklyn, New York 11236. New York Medical 1966. Board eligible. Partnership or solo. Available, June 1971.

Yurdakul Omay, M.D., 2106-R West Otley Road, Peoria, Illinois 61604. Ankara (Turkey) University 1956. Salaried, group, or partnership. Available.

OPHTHALMOLOGY—Stephen H. Franklin, M.D., 555 East William Street, Ann Arbor, Michigan 48108. NYU Downstate 1963. Solo or association. Available, March 1971.

Jose Minaya, M.D., 1106 Lyndon #10, Houston, Texas 77025. San Marcos (Lima, Peru) 1962. Board eligible. Group or partnership. Available.

PEDIATRICS—Parviz Pishva-Zadeh, M.D., c/o Todaro, 5601 14th Avenue, Apt. 4F, Brooklyn, New York 11210. Tehran (Iran) 1959. Board certified. Solo or partnership. Available.

Elliott S. Tokar, M.D., 130th General Hospital, APO New York 09096. University of Maryland 1965. Board eligible. Group. Available August 1971.

I. Arshad. M.D., 5735 Kings Highway, Brooklyn, New York 11203. Gandhi Medical (India) 1962. Board eligible. Group or partnership. Available.

Ayhan Erinc, M.D., 7101 South Adams Street, Peoria, Illinois 61607. Ankara, Turkey 1958. Board eligible. Group, Partnership. Emergency Room, House Physician.

Philip H. Friedman, M.D., 287 Dickman Drive, Loring AFB, Maine 04750. NYU (Downstate) 1965. Board certified. Group or partnership. Available, February 1971.

Ali Jahromi, M.D., 515 East 7th Street, Brooklyn, New York 11218. Tehran (Iran) Medical School 1968. Board certified. Solo or group. Available.

SURGERY—Edward Mussad, M.D., 115-D Fort Lee Road, Leonia 07605. Cairo University, 1957, Board certified. Group, partnership, or solo (commuting distance New York City). Available.

Y. M. S. Bushan, M.D., 1704-55 Triller Avenue, Toronto 156, Canada. Bangalore Medical College 1961. Board certified. Partnership or group. Available.

P. B. Dandade, M.D., At and PO, Undri District, Buldana, M.S., India. Nagpuv University (India) 1962. Board eligible. Subspecialty, thoracic and cardiovascular surgery. House physician, emergency room or group. Available as soon as visa granted—January 1971 or before if sponsored.

A. Sergie, M.D., 2035 Pine Street, Philadelphia, Pennsylvania 19104. Paris Medical School (France) 1955. Board eligible. Group or partnership. Available.

Mehdi B. Javan, M.D., 120 North Mole Street, Philadelphia, Pennsylvania 19102. Pahlavi (Iran) University 1961. Board certified. Subspecialty, cardiothoracic surgery. Group or partnership. Available July 1971.

UROLOGY—R. Soundararajan, M.D., 6439 North Broad Street, Philadelphia 19126. Madras University (India) 1959. Partnership or group. Available August 1970.

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Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during August:

	1970 August	1969 August
Aseptic meningitis	53	12
Primary encephalitis	3	2
Infectious encephalitis	0	0
Hepatitis: total	29	197
Infectious	233	164
Serum	63	33
Malaria: total	4	22
Military	3	19
Civilian	1	3
Meningococcal meningitis: total	10	4
Military	3	1
Civilian	7	3
German measles	12	13
Measles	31	32
Salmonella	126	45
Shigella	23	15
Mumps	26	19

Salmonellosis in a Summer Camp

A major outbreak of salmonella gastroenteritis occurred over a several day period in a northern New Jersey residential summer camp. The over-all attack rate was 64 per cent among 221 children and counselors at the camp. *Salmonella thompson* was isolated from two food items and nearly all stool specimens which were submitted for bacteriologic culture. Clinically, the primary manifestations of illness were diarrhea (81 percent), abdominal pain (80 percent), fever (80 percent), nausea (65 percent), and vomiting (54 percent). Dehydration constituted a prominent feature of the outbreak because the prevailing hot weather aggravated fluid and electrolyte disturbances produced by the vomiting and diarrhea. Twenty-six children were hospitalized for their illness.

The initial wave of illness developed within 48 hours after a Saturday turkey dinner. A differential attack rate of 19 per cent was calculated between individuals who ate and those who did not eat the turkey, contrasted to either negative or small positive differential attack rates for other food items. Significantly, *all* people who became ill in the first wave consumed turkey. All of those who did not eat turkey remained well. A larger secondary

wave of illness (at least 82 cases) occurred after a Monday meat loaf dinner and large differential attack rates (22 to 66 percent) were found for the items served at this meal. *Salmonella thompson* was isolated from the left-over green beans and meat loaf that had been served at this meal.

It is hypothesized that the offending pathogen was initially introduced in an infected turkey used in the Saturday evening meal, and that other food items were subsequently contaminated through inadequate sanitization of pots and utensils. Additionally, the potable water supply was found to be contaminated with coliform organisms. The unusual severity of the outbreak necessitated the closing of the camp.

Behind The Drug Scene

Methadone Treatment

Not too long ago talented Bill Cosby took a piece of Americana and recorded it. In a kindergarten, children are learning math by chanting one and one equal two. The chanting increases as the children apparently learn until one child asks the teacher—what's one?

It may very well be that the same thing is going on with the use of methadone for the treatment of narcotic addicts.

More than 4,000 narcotic addicts are currently being treated by methadone maintenance; new centers are being opened quickly; a third national conference on methadone treatment is to be held in the fall; government guidelines and committees are being formed; and, since it is an election year, politicians are either avidly for or against it.

So, what is methadone and what is all the chanting, pro and con its use about?

Methadone is a synthetic narcotic, or pain killer, developed by the Germans during World War II when other naturally derived pain killers were not available. It continues to be used in easing pain for chronic illnesses, such as cancer.

A little over five years ago Dr. Vincent Dole, of New York City's Rockefeller University, discovered that when a person was kept on a relatively high dose daily, after being brought up to that dose over a period of weeks, he did not feel the "high" of other narcotics, such as heroin for about 24 hours, and did not have a desire for other narcotics.

Thus, a person, who had gone through many years of drug related arrests and jailings and numerous treatments which didn't really change the way he was living, could now hope to return to a normal way of living because he would no longer be so involved in looking for narcotics, getting implicated in illegal behavior to support his habit, and generally being a drain on his family, friends, and the community. This sounds as if our communities' narcotic problem is just about over. Two thousand addicts are being rehabilitated this way in the Dole-Nyswander program in New York City and about 100 in the New Jersey State program.

The way we presently measure success in such a program is whether the person is working, drug free, and little involved with the law.

Methadone, in the way it is used to keep narcotic addicts free of illegal narcotics' use, is classified as a narcotic antagonist. This last sentence is written in this way to remind us that it effects only narcotics, not other types of drugs.

A drug antagonist has no effect on the behavior of a person itself. It simply takes up physical space in a person's system, and in a sense shields that person from being affected by any narcotic he may be using. Methadone at a low dose works this way, and at a higher daily dose it serves as a blocking agent, stopping the person's desire for narcotics.

Methadone has the advantages we get from other good medicines. It is easily available, not too expensive, and becoming increasingly acceptable to addicts, the people who treat

them, and to us in the general community. Its distribution can be controlled so that it doesn't easily get into the illegal market. It is available in liquid drinking form so we don't need special technics to administer it. There are few, if any, serious side effects, and in the not too distant future it may come in a form that lasts three days at a time.

The one thing we are not that sure of, however, is whether, by itself, it can bring a person back to conventional ways of living, particularly if the person was not living a conventional life before he began using narcotics. Methadone treats a narcotic drug condition and not the condition of being a person with strengths and weaknesses. This brings us to the question of what is rehabilitation all about. This means getting a person to strive to achieve goals that are meaningful for and achievable by him, and of which society approves.

Since there are no magic solutions, drugs or otherwise, for the problems of living, what we generally hope for is to help people feel more comfortable about turning to others to meet their needs. This we call "trust." When we combine trust with hope, learning from experience, and a few other things that make up being mature, then we arrive at rehabilitation. No drug, short or long acting, can cause this to occur, since this often takes a lifetime to achieve.

At best, methadone can serve as one of many tools in helping narcotic addicts. What is needed at the present time is for us to know who should be in methadone treatment, and at what point should this occur in their drug abuse treatment career. To know this we must understand whether methadone patients who succeed are really like other narcotic addicts. Or are they different? We must understand if the criteria for accepting narcotic addicts into this type of treatment makes sense. For example, only four per cent of New Jersey's addicts have been accepted into such treatment these last few years. These issues and many others need to be answered through clear thinking and relevant research.

205th Annual Meeting
The Medical Society of New Jersey
May 15-18, 1971
Haddon Hall, Atlantic City

Tentative Program Outline

Friday, May 14, 1971

3:00 p.m. — Installation of Exhibits
4:00 p.m. — Board of Trustees

Saturday, May 15, 1971

9:00 a.m. — Installation of Exhibits
10:00 a.m. — Registration Opens
12:00 noon — Exhibits Open
1:00 p.m. — Golden Merit Award Ceremony followed by Reception for GMA Recipients and Their Families
2:30 p.m. — House of Delegates followed by General Session
4:00 p.m. — Open Discussion on MSP
4:30 p.m. — Nominating Committee
7:00 p.m. — Officers' Dinner
7:00 p.m. — Reception-Buffet Dinner for Technical Exhibitors

Sunday, May 16, 1971

9:00 a.m. — Registration and Exhibits Open
9:30 a.m. — Scientific Sessions
10:30 a.m. — Coffee-Meeting with Reference Committee Chairmen
11:00 a.m. — Reference Committees
1:00 p.m. — Scientific Sessions
3:30 p.m. — House of Delegates (election) followed by Address of President and President-Elect
6:00 p.m. — Inaugural Reception
8:00 p.m. — Inaugural Dinner

Monday, May 17, 1971

9:00 a.m. — Registration and Exhibits Open
all day — Scientific Sessions
5:00 p.m. — Exhibits Close
7:00 p.m. — Annual Dinner Dance

Tuesday, May 18, 1971

9:00 a.m. — Registration Opens
9:00 a.m. — House of Delegates
12:00 noon — Registration Closes

Wednesday, May 19, 1971

8:30 a.m. — Board of Trustees

The Instant Of Death ... Or The Process

Once it was very simple. A person was dead when the doctor pronounced him dead. Occassionally a legal situation would develop where it was important to know whether a person had died just before or just after midnight; or when two people were killed in a common accident, to determine which one died first. But these were rare cases. In general, it made no practical difference whether the deceased formally and "officially" died at 10 a.m. or at 10 p.m.

But transplantation has changed all that. You can't take a heart out of a person who is still "alive." But if you wait too long after death has certainly occurred, the heart may be useless for transplant purposes. And so with dramatic suddenness there has leaped into importance a new question. When is the instant of death? Of course, we know that there is no "instant." Death is a process, not a moment. But if we, in our profession, don't develop a way of fixing that moment, the law or the Church or somebody is going to do it for us.

Under the auspices of the Academy of Medicine of New Jersey, with an assist from Hoffmann-LaRoche, a symposium was held on this subject in Nutley last year. Out of this, the moderator of the session (Arthur Winter, M.D., member of The Medical Society of New Jersey) has developed a book published by Charles C. Thomas of Springfield, Illinois. Retailing at $6, this is a hard-backed, 84-page volume, collecting the presentations of the participants in the symposium, including some of the discussion and dialogue, the text of the uniform anatomical gift act (now the law in our state), and some correspondence on the subject from experts.

The symposium opened with a presentation by the distinguished New York clinician, Irving S. Wright, M.D. Dr. Wright pointed out that the old phrases, "the patient ceased to breathe at . . ." or "heart action stopped at . . ." are no longer satisfactory time-setters for the moment of death. Like most participants in this colloquium, he felt that cessation of brain function was the most critical index of the instant of death. He then tackled the question of who should make the decision, who should have the say as to when to turn off the switch of the respirator and pull out the tubes, who should say unequivocally that this patient is dead. "Decisions involving the life and death of individuals are the daily challenges of physicians and surgeons. They are better equipped to meet these challenges than any other group in our society. This is what they (doctors of medicine) live with." Dr. Wright agreed that, at times, the decision should be made by a team of physicians, and that some consideration must certainly be given to the views of the relatives, the clergy, philosophers, and attorneys, but it is always the M.D. or a panel of them who must take full responsibility for this decision.

The second contributor was Earl A. Walker, M.D., professor of neurosurgery at Johns Hopkins (who prefers, in this context, to identify himself as a "neuroscientist" rather than as a "neurosurgeon"). He lists the electro-encephalographic and clinical evidences of a "dead brain," and adds such findings as lack of response to the injection of icewater into the ear, unresponsiveness to painful stimuli, and dilated fixed pupils.

Dr. Walker was followed by Joseph J. Timmes, M.D., a thoracic surgeon and a member of The Medical Society of New Jersey. Dr. Timmes' comments that, "some surgeons, in their eagerness to perform organ transplants, do require a certain restraint. However, the current legislative restrictions present serious obstacles to the march of medical progress." Dr. Timmes reminds us that, "the heart can be put in cold storage for from four to seven hours and still be used in a successful transplant." He endorses the "Harvard criteria" to define death: (1) failure to react to pain and other noxious stimuli; (2) no breathing; and (3) no reflexes. This formula considers the flat electro-encelphalogram only confirmatory. "Once brain death is established the physician is medically and morally justified in turning off the respirator."

Speaking as our state's chief medical examiner, Dr. Edwin Albano (also a member of The Medical Society of New Jersey) points out that you often cannot depend on the traditional indicia of death: absence of heartbeat, lack of respiratory movements, fixed, dilated pupils, and absent tendon reflexes. We die by inches, he reminds us, and some biological activities can indeed remain after clinical death has occurred. But, Dr. Albano points out, "Once the brain has suffered irreversible damage, no amount of oxygenated circulation will restore its original state." Dr. Albano also reviews, in a highly practical way, situations under which resuscitative measures are and are not justified, and sees no merit in keeping biologic existence going by artificial means after irreversible damage has destroyed all cerebral activity. "Such an individual," he says, in accurate, if colorful, language, "ceases to be a human being and becomes a mass of protoplasm."

Up to this point, the symposium had proceeded in a frame of reference familiar to most M.D.s. Now, Arthur Sills (who, at that time, was Attorney General of New Jersey) took the platform to discuss the legal implications of fixing the instant of death and revealed many angles that most physicians would not have thought of. He makes a distinction between sustaining life by artificial means and extending every effort to maintain spontaneous life. Withdrawing artificial means, he suggests, "lies uncomfortably close to the problem of euthanasia." This kind of distinction probably seems more meaningful to the juridical philosopher than to the medical doctor. Not too long ago, he tells us, a person could not, by will, dispose of his own dead body. At the same time, the heirs did not have a property right in the corpse. (New Jersey's anatomical gift act now specifically says that "any individual of sound mind and of 18 (or more) years of age may give all or any part of his body . . .") Mr. Sills also comes to grips with the serious moral and ethical problem of whether the physician "kills" the patient by turning off the switch. He quotes George Fletcher (not further identified) who, in an article in a legal journal, proposed distinguishing *causing* death from *permitting* it to happen, if the latter is what would have inevitably happened anyway. The latter kind of action (or inaction) he feels would not subject the physician to legal or to moral liability.

Christian Barnard, in a letter published in the appendix to this volume, suggests that we are all talking too much about this problem. Dr. Barnard is particularly annoyed at the suggestion that separate medical teams be called in to diagnose the death and to do the transplant surgery. This, he fears, suggests that doctors can't be trusted. It is an interesting thought, and presumably, it is a call for a moratorium on further talk about this subject.

Dr. Adrian Kantrowitz, in testimony before a United States Senate Committee, said that if the brain is deprived of oxygenated blood for four minutes it would suffer irreversible damage. "In the event that this patient is saved, his heart, liver, and kidneys may function for years. He will be alive but without a human personality." In this testimony (published as an appendix to this book), Dr. Kantrowitz recites some rather uncomfortable figures. He estimates that 500,000 persons a year would be candidates for heart transplants (or for mechanical hearts) but only 10,000 persons die each year of serious brain injury. Only half of these victims have hearts suitable for transplanting. In effect then, 5,000 hearts would be available for 500,000 possible recipients, a one to a hundred ratio, which means that someone or some agency has to decide who gets a priority on the right to continue living. Death, he says, is not a moment or an instant. It is the point of no return along the path of the death process.

This is a stimulating and thought-provoking book. It has to be savored in full to grasp this problem in depth. The editors and contributors have assigned all profits from this book to the Academy of Medicine of New Jersey. In all respects, this is a unique volume. Nothing quite like it has ever been written before.

The Academy Is For You

The Medical Society of New Jersey and its component county societies are your premier organizations for the administrative, organizational, legislative, and medico-legal problems in our field. For the educational, research, and top-level scientific activities, the Academy of Medicine is your best bet. This unique, 60-year old Academy operates one of the largest and most accessible medical libraries in our state. It brings together physicians, dentists, and members of allied biologic sciences in a scientific colloquium. The Academy operates graduate educational programs at various levels and at various places. Fellowship in the Academy is a badge of devotion to the scientific aspects of our profession. Any member of The Medical Society of New Jersey is eligible to join. For more information, write to the Academy at 307 Belleville Avenue, Bloomfield, New Jersey 07003. Although its administrative headquarters is in Bloomfield, its activities (including graduate educational programs) cover the state from the top of Sussex to the bottom of Cape May. This Academy is for you!

The Boston Convention

The 24th Clinical Convention of the American Medical Association will be held November 29 to December 2 in Boston.

"This year's clinical convention reflects the growing needs of the busy practicing physician," declared Charles D. Bussey, M.D., Chairman of the AMA's Council on Scientific Assembly. "A scientific program has been prepared to serve and interest both the general practitioner and the specialist. Motion pictures, courses, lectures, round table discussions, and scientific and industrial exhibits will combine to further their postgraduate and continuing education."

"The AMA clinical convention offers an overview of medical practice that is rarely found at specialty society meetings," said Claude E. Welch, M.D., Boston, program chairman. The opening day, Sunday, November 29, will be devoted to registration and to viewing and studying scientific and industrial exhibits at Boston's Civic Auditorium. The study program will get down to intensive work early Monday morning, November 30, and continue without letup through Wednesday, December 2. The working day will begin at 7:30 a.m., with a special graduate course each morning, continuing until 8:50 a.m. Courses will be available on "Anesthesia and Immediate Postoperative Care," "Fluid and Electrolyte Balance," and "Treatment of Burns."

From 9 a.m., each day, you will be able to select among three general scientific sessions each morning period, and three more each afternoon, for a total of 18 half-day general sessions. Each will cover one aspect of medical care. Study will continue through the lunch period, with three luncheon round tables scheduled each day for three days, at the Sheraton-Boston Hotel. The round tables will feature informal question-and-answer type study. Senior experts in each of the subject areas will be present to lead the discussion and to answer queries.

Highlights of the scientific program will be channeled by closed-circuit television to the hotel rooms of physicians attending the convention in the early morning and evening hours. This will permit doctors to obtain summaries of reports at meetings they were unable to attend because of conflicting schedules.

The new film to be premiered will be "Postpartum Hemorrhage," second in the *Modern Obstetrics* series. It received the Golden Eagle award of the Council on International Nontheatrical Events.

Also scheduled during the convention are meetings of the AMA House of Delegates, and just prior to the opening of the convention, the Medical Services Conference (Saturday, November 28). The theme of this session is "New Methods of Delivery of Health Care."



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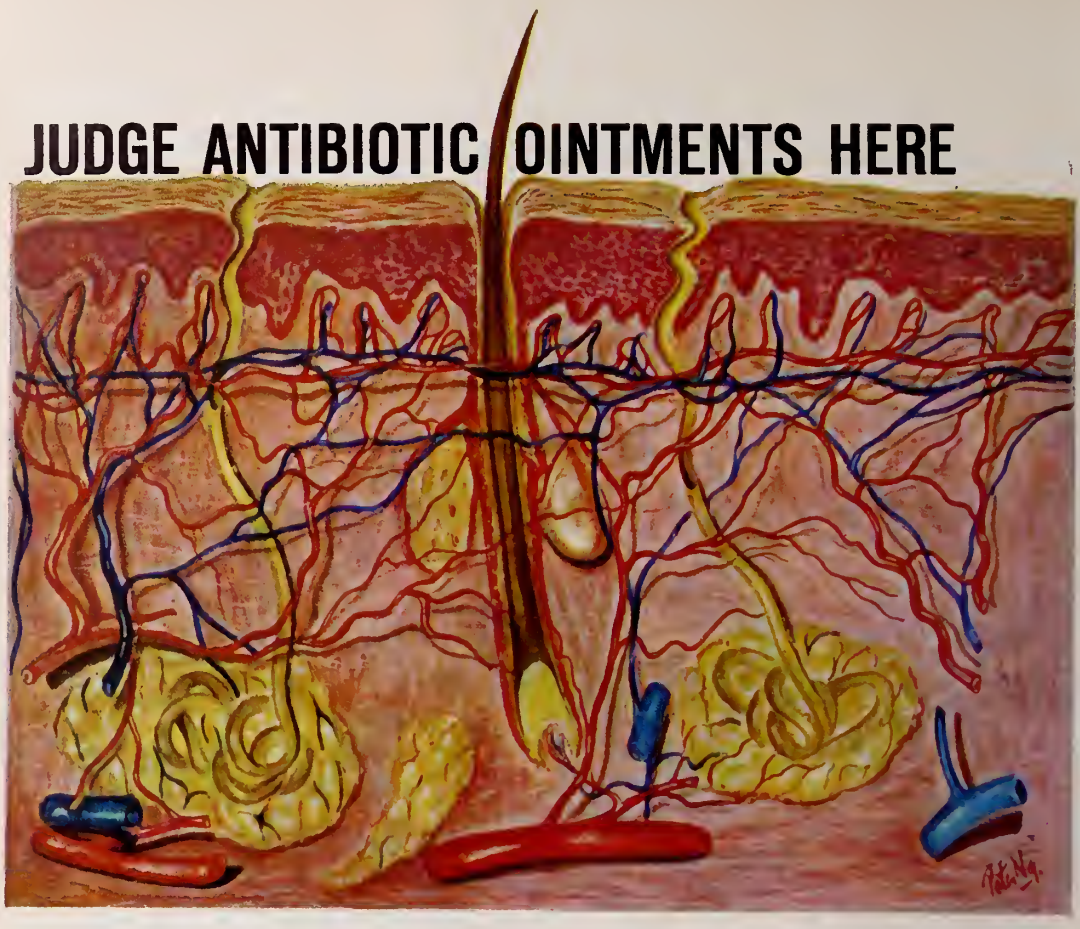
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Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
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ANNOUNCEMENTS

Cardiology For The Family M.D.

The Columbus Hospital in Newark announces its ninth annual course in simplified electrocardiography for the family physician. The first session will be on October 7, 1970 and the last on May 19, 1971. All meetings are held at 10 a.m. on Wednesdays and run for two hours each. Credit allotment will be given by the American Academy of General Practice. The fee for the entire program is $100. For more details, write to Dr. Michael C. Ritota, Director, Department of Medicine, Columbus Hospital, 495 North Thirteenth Street, Newark 07107.

You and the Diabetic

The New Jersey Department of Health, in conjunction with the New Jersey Diabetic Association, has made available for you a program on the doctor and the mild diabetic. The symposium will be held from 2 to 4:30 p.m. on Wednesday, October 21 at the East Orange General Hospital. Following the speaker, there will be case presentations and a question and answer period. Questions may be submitted in writing to Dr. Louis Grunt (program chairman) 70 South Munn Avenue, East Orange 07018.

Clinical Application Of Basic Sciences

The November programs in the Burlington County Memorial Hospital's "Basic Sciences and Clinical Applications" series will cover the following:

November 5	Emergency Diagnosis and Therapy of Carotid Arterial Disease
November 12	Acute Abdominal Trauma: Evaluation and Management
November 19	Burns: Current Concepts of Therapy

All meetings convene promptly at 3:30 pm. and are held in the T. J. Summey Building at the Hospital. Attendance is accepted for credit by the AAGP. For further information, please contact the Department of Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Symposium on Management of Shock

You are invited to attend a symposium on management of shock at the Montclair Community Hospital on Wednesday afternoon, November 11, in the Conference Room in the North Wing. The American Academy of General Practice has approved four credits for attendance at this meeting. Following the session there will be a discussion. Dinner, which includes a hospitality hour, will be held at Rod's 525 Northfield Avenue, West Orange. The fee is $15. There is no charge for attending the symposium. For further information, please contact Stanley Fieber, M.D., 588 Eagle Rock Avenue, West Orange 07052.

Psychosomatics In Bermuda

Readers of this *Journal* have an opportunity of combining a trip to Bermuda in the fall with a graduate course in "the treatment of emotional illness." This combination is made possible by attending the 17th annual meeting of the Academy of Psychosomatic Medicine in Hamilton, Bermuda, November 15 to 19. For details on how to do it, write to Dr. Edward Dunlop, 150 Emory Street, Attleboro, Massachusetts 02703.

Medical Aspects Of Sports

The 12th National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association, will be held in Boston on November 29, 1970 at the Sheraton-Boston Hotel. The conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association. The program includes forums and discussion sections relating to research in sports, aquatic sports, football injuries, psychology in sports, girls in sports, and emergency and public health aspects of

sports. Francis D. Moore, M.D., Professor of Surgery, Harvard Medical School, will discuss the topic, "Sailing into Trouble." Demonstrations on preventive and therapeutic taping, and musculo-skeletal aspects for pre-participation examination will be staged. For further information, write to the Committee on the Medical Aspects of Sports, AMA, 535 North Dearborn Street, Chicago.

Nutrition Meeting In Boston

The American College of Nutrition will hold its Annual Meeting in Boston, November 29, 1970. The session will be at the Sheraton-Boston Hotel. The program reviews advances in diseases of nutrition and metabolism. It is open to all physicians without charge. For more details write to Dr. Seymour L. Halpern at 146 Central Park West, New York 10023.

Pediatric Cardiology

A pediatric cardiology graduate course will be presented by the American Academy of Pediatrics and the University of Florida College of Medicine, December 9 to 12, 1970, at the Happy Dolphin Inn, Saint Petersburg Beach, Florida. For more details write to Dr. Gerald Hughes, American Academy of Pediatrics, P.O. Box 1034, Evanston, Illinois 60204.

Hypnotherapy Course

Physicians, regardless of specialty, may now take the annual and basic course in medical hypnosis sponsored by Columbia University College of Physicians and Surgeons. This is given on each Saturday in January 1971, and the tuition for the four sessions is $175. The course includes lectures, case demonstrations, moving pictures, seminars, and practice sessions, and will present the use of hypnosis as an adjunct to the clinical practice of medicine. For more information, write to the Associate Dean, College of Physicians and Surgeons, 630 West 168th Street, New York 10032.

Otolaryngology: 1971

The Department of Otolaryngology of Jefferson Medical College (Thomas Jefferson University, Philadelphia) announces a graduate symposium April 1 and April 2, 1971. Theme will be "Therapy in Otolaryngology—1971." It focuses on both medical and surgical treatment and includes otology, rhinology, sinus disease, allergy, head and neck cancer, trauma, and maxillofacial surgery. Registration fee of $50 for practicing physicians and $10 for residents will include lunches on both days, and a dinner meeting. For further information, write to William H. Baltzell, M.D., Department of Otolaryngology, Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

Family Practice Examination

The American Board of Family Practice announces its *second* examination for certification will be held February 27 and 28, 1971 in various centers throughout the United States. For application, write to Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506. Deadline for applications is November 1, 1970.

Orthopedic Fellowship Competition

The International Society of Traumatic and Orthopedic Surgery (SICOT) is announcing a "Congress Fellowships" to the October 1972 meeting in Israel. Specifically, the Israeli section of SICOT, in conjunction with that country's Orthopedic Association, is offering 15 travel fellowships to the SICOT Congress which will take place in Israel from October 9 to 13, 1972. This fellowship includes free air travel and seven days, full board, in Israel.

The fellowship is a scientific competition for the best original paper on an orthopedic subject or any basic subject connected with that field of interest. The competition is open to every surgeon or traumatic scientist born in 1929 or later.

For more details write to the SICOT office in Belgium: Société Internationale de Chirurgie, Orthopédique et de Traumatologie, 43, rue des Champs-Elysées, Bruxelles 5, Belgique. Final date for submission of papers is January 31, 1972.

LETTER TO THE JOURNAL

Why Exempt The Physician?

July 20, 1970

Dear Sir:

At the present time, there is a bill (S-838) * in committee amending the Medical Practice Act as follows:

"Any employee of a duly licensed hospital of this State holding a degree of M.D., regularly employed on a salary basis on its medical staff, may apply to the State Board of Medical Examiners, and may, in the discretion of said board, be granted exemption from the provisions of this chapter; provided said employee is limited to the performance of emergency medical service under the direct supervision of duly licensed physicians of this State serving as members of the active staff of such hospital and providing such employee does not conduct any type of private medical practice."

On July 12, 1970, the New Jersey Hospital Association sent a letter to all member institutions stating that the Association had voted to support S-838 with any necessary amendments, and to meet with all responsible organizations such as the Medical Society and the State Board of Medical Examiners to secure their support for any such legislative program. This bill requires detailed discussion and analysis. It proposes to exempt any employee of a licensed hospital based upon the holding of an M.D. degree as long as he is employed on a salaried basis and a member of the medical staff. The bill places the cart before the horse in two instances: first, the physician must be employed before the exemption can be claimed, and secondly, he must be a member of the medical staff *prior* to claiming the exemption. I believe it illegal for a hospital (unless otherwise exempt) to employ unlicensed physicians and I do not believe that any hospital (unless otherwise exempt) permits unlicensed physicians on its medical staff, unless in its internship and residency programs.

It is possible that the bill is attempting to create a totally new class of exempt physician, since it recognizes the presence of salaried M.D. employees on the staff in need of exemption. Then the bill goes on to state that the physician may apply for exemption, but when? Apparently only after the physician is in violation of the Medical Practice Act.

The exemption proposed is "at the discretion of the State Board of Medical Examiners." Since the word *discretion* either implies prudence or caution, or permits a wide latitude of action, how can the proposer of the amendment presume that the board will even allow the exemption?

The restriction of the exempt physician's practice to that of an *emergency* nature sounds like a bona fide qualification. However, the term *emergency* serves to cloak the proposal in the illusion of legitimacy which it hardly deserves. It will be possible that the exempt physician will be the only available physician in a given situation. Therefore, anything he does may be termed an *emergency*.

The use of the term *medical* in conjunction with what the exempt physician may do raises another question. Does the proposer exclude surgery from the practice of the exempt physician? Or, does he use the term *medical* in its generic sense to mean all branches of medicine including surgery? The broader definition is more likely the correct one in order for the exemption to be meaningful. In this case it will be interesting to see what happens when the *exempt* starts doing, for example, emergency appendectomies or caesarean sections.

The use of the term *direct supervision* implies that someone has to be present to tell the *exempt* physician what to do, but he must also be present to supervise his performance. This would negate the usefulness of the exempt physician because, if he requires this type of supervision, then whoever is there to give it could just as well do the job. Also,

* The official position of The Medical Society of New Jersey on S-838 (by action of the Board of Trustees, July 19, 1970) is DISAPPROVED. The New Jersey State Board of Medical Examiners is also officially opposed to this bill.

since this direct supervision must be done by a licensed physician, what is his legal responsibility?

The proposal says that this direct supervision must be given by members of the active medical staff of the hospital. Does this mean that physicians who are not members of the active staff (and they may be many) have no responsibility here? Will the members of the active staff be responsible for the direct supervision of the exempt physician in the care of patients of physicians not on the active staff? Conversely, will the patients of the non-active staff physicians be eligible for care by the exempt physicians?

The exempt physician is prohibited from conducting any type of private medical practice. Does it merely mean that the exempt physician cannot open an office outside of the hospital, or that he may not bill a patient in his own name?

The amendment creates a category of physician exempt from the Medical Practice Act, who may treat only emergencies under direct supervision as a salaried employee of a hospital and a member of its medical staff. The problem that this type of physician represents becomes clear only when the key word of the amendment, the word *service,* is understood. This *service,* in reality, is to be given in the hospital by the exempt physician to the patient for the benefit of the duly licensed physician. As long as the needs of patients, the requirements of hospitals, and the attitudes of physicians are so far apart, this type of legislation will find support. However, it begs the issue, it short-changes the patient of medical care of adequate quality, and makes hospitals the purveyors and initiators of medical care through the medium of physicians who are above the licensure process. Moreover, these exempt physicians are not even limited in time. This appears to be a lifetime employment situation.

Many hospitals in New Jersey are forced to pay high salaries for house physicians because medical staffs are not assuming their responsibilities. Thus, it appears that soon there will be no reason for many physicians in New Jersey to apply for licensure. Conversely, hospitals will have no further need for properly qualified personnel and will not in the future even need a qualified medical staff except in a supervisory capacity.

(signed) Gerard J. Aitken, Jr., M.D.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

October

7 **St. Barnabas Medical Center**
Department of Obstetrics and Gynecology
Livingston
Pathology Course in Obstetrics and Gynecology

7 **Academy of Medicine of New Jersey**
Academy of Medicine Offices
Bloomfield, New Jersey
Round Table on Internal Medicine

7, 14, **Columbus Hospital**
21, 28 Hospital Annex, Newark
Simplified ECG for the family physician

9 **Academy of Medicine of New Jersey**
Saint Barnabas Medical Center
Livingston
Ventilatory Management of Infants and Children

14 **TB-Respiratory Disease Association of Southern New Jersey**

14 **Middlesex County Medical Society**

14 **Ocean County Medical Society**

14 **Bergen County Medical Society**

14 **Cumberland County Medical Society**

14 **Academy of Medicine of New Jersey**
Saint Michael's Hospital, Newark
Pulmonary Disease

14 and 28 **St. Barnabas Medical Center**
Department of Obstetrics and Gynecology
Livingston
Pathology Course in Obstetrics and Gynecology

14 and 21 **Academy of Medicine of New Jersey**
Neurological Institute of Health
New York City
Neurology

15 **Morris County Medical Society**

15 **Gloucester County Medical Society**

15 **Burlington County Memorial Hospital**
Mount Holly
Control of Respiration and Relationship to Oxygen Therapy

16 **Academy of Medicine of New Jersey**
Mount Sinai Hospital, New York
Sarcoidosis

21 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Pleural Effusion

21 **New Jersey State Diabetes Association**

22 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Resuscitation of Newborn

22 **Burlington County Memorial Hospital**
Mount Holly
Artificial Airways, Oxygen Delivery, and Humidification

24 **New Jersey Historical Society and Academy of Medicine of New Jersey**
State Museum Auditorium, Trenton
New Jersey Medical History Symposium

28 **Academy of Medicine of New Jersey**
Section on Urology
Marriott Motor Inn, Saddle Brook
Renal Calculus Disease

28 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Asthma and Allergic Disease of the Lungs

28 **Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Esophageal Disease

29 **Burlington County Memorial Hospital**
Mount Holly
Mechanical Ventilation in Respiratory Failure

November

3 **Hudson County Medical Society**

4 **Academy of Medicine of New Jersey**
St. Vincent's Medical Center
New York City
Isotope Scanning of Lung, Liver, and Spleen

4, 11 and 18 **Academy of Medicine of New Jersey**
Mountainside Hospital
Montclair
Esophageal Disease

4, 11, 18, 25 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

5 **Burlington County Memorial Hospital**
Mount Holly
Carotid Arterial Disease

6-7 **American Psychiatric Association, Medical Society of New Jersey, New Jersey Academy of General Practice, and Academy of Medicine of New Jersey**
Hotel Robert Treat, Newark
Biological Frontiers of Psychiatry

7, 14 **Jersey City Medical Center**
Jersey City
Anesthesiology Fall Seminar

11 **New Jersey Chapter, American College of Physicians, and New Jersey Society of Internal Medicine**
Holiday Inn, Trenton
Annual Meeting

11 **Bergen County Medical Society**

11 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Infectious Disease

11 **TB-Respiratory Disease Association of Southern New Jersey**

11 **Ocean County Medical Society**

11 **Middlesex County Medical Society**

12 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Renal Disease

12 **Burlington County Memorial Hospital**
Mount Holly
Acute Abdominal Trauma

18 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Fever of Unknown Origin

19 **Burlington County Memorial Hospital**
Mount Holly
Burns: Current Therapy

19 **Morris County Medical Society**

19 **Gloucester County Medical Society**

30 **Cape May County Medical Society**

December

2 **Hudson County Medical Society**

2 and 9 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Uremia

2, 9, 16, 23, 30 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

3 **Burlington County Memorial Hospital**
Mount Holly
Intensive Radiation Therapy

3-4 **Academy of Medicine of New Jersey**
Saint Barnabas Medical Center,
Livingston
Culdoscopy Workshop

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

8 **TB-Respiratory Disease Association of Southern New Jersey**

8 **Ocean County Medical Society**

8 **Middlesex County Medical Society**

9 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Pulmonary Disease

10 **Burlington County Memorial Hospital**
Mount Holly
Antimicrobial Agents

16 **Academy of Medicine of New Jersey**
Bergen Pines Hospital, Paramus
Coronary Cineangiography

16 **Academy of Medicine of New Jersey**
Mount Sinai School of Medicine
New York
Hematology

16 **Academy of Medicine of New Jersey**
Cornell Medical Center, New York
Transplantation

17 **Morris County Medical Society**

17 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar

1971

January

5 **Hudson County Medical Society**

6, 13, 20, 27 **Columbus Hospital**
Hospital Annex
Simplified ECG for the family physician

6, 13, 20, 27 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Cardiology

7 **Burlington County Memorial Hospital**
Mount Holly
Lymphoid-Immune System

10 **Bergen County Medical Society**

10 **Gloucester County Medical Society**

10 **Warren County Medical Society**

10 **TB-Respiratory Disease Association of Southern New Jersey**

10 **Ocean County Medical Society**

10 **Middlesex County Medical Society**

14 **Burlington County Memorial Hospital**
Mount Holly
Immunity, Genetics, and Virus Infections

21 **Burlington County Memorial Hospital**
Mount Holly
Immune Mechanisms in Lupus Erythematosus and Rheumatoid Variants

28 **Burlington County Memorial Hospital**
Mount Holly
Immunologic Abnormalities in Neurologic Diseases

February

2 **Hudson County Medical Society**

3 and 10 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Cineangiography

3, 10 17, 24 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Cardiology

3, 10, 17, 24 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

4 **Burlington County Memorial Hospital**
Mount Holly
Immunology and Neoplastic Diseases

4 **Saint Barnabas Medical Center,**
Livingston
Hormonal Cytology

11 **Burlington County Memorial Hospital**
Mount Holly
Fibrinolysis and Fibrinolytic Agents

18 **Burlington County Memorial Hospital**
Mount Holly
Emotional and Psycho-social Maturation

24 **Academy of Medicine of New Jersey**
Albert Einstein Medical Center,
Newark
Pediatric Renal Disease

25 **Burlington County Memorial Hospital**
Mount Holly
Physiology of Puberty and Psycho-sexual Maturation

March

2 **Hudson County Medical Society**

2 **Academy of Medicine of New Jersey**
Section on Dentistry
Academy of Medicine Offices,
Bloomfield

3, 10, 17, 24, 31 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

4 **Burlington County Memorial Hospital**
Mount Holly
Management of Infertile Couple

4 **Academy of Medicine of New Jersey**
National Institutes of Health
Bethesda, Maryland
Clinical Infectious Diseases

4 Saint Barnabas Medical Center
Livingston
Multiparous Trap

9 Bergen County Medical Center

9 TB-Respiratory Disease Association of Southern New Jersey

9 Middlesex County Medical Society

10 Academy of Medicine of New Jersey
Overlook Hospital, Summit
Respiratory Failure

11 Burlington County Memorial Hospital
Mount Holly
Sexual Problems Seen in Office Practice

17 Academy of Medicine of New Jersey
Cornell School of Medicine, New York
Cardiac Drugs

18 Morris County Medical Society

18 Gloucester County Medical Society

18 Burlington County Memorial Hospital
Mount Holly
Biochemical Parameters of Aging

24 Academy of Medicine of New Jersey
Dental Section
Veterans Hospital, East Orange
Symposium

24 Academy of Medicine of New Jersey
Massachusetts General Hospital, Boston
Gastrointestinal Disease

25 Burlington County Memorial Hospital
Mount Holly
Hyperlipoproteinemias

29 Cape May County Society

31 Academy of Medicine of New Jersey
Cornell Medical Center, New York
Heart Surgery

31 Academy of Medicine of New Jersey
Symposium—Controversy in Medicine

April

1 Burlington County Memorial Hospital
Mount Holly
Pre-diabetic Syndrome

6 **Hudson County Medical Society**

7 and 14 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Uremia

7, 14, 21, 28 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

8 **Burlington County Memorial Hospital**
Mount Holly
Recent Advances in Diabetes Mellitus

8 **Saint Barnabas Medical Center**
Livingston
Irradiation Therapy

13 **Cumberland County Medical Society**

13 **Bergen County Medical Society**

13 **Middlesex County Medical Society**

14 **TB-Respiratory Disease Association of Southern New Jersey**

15 **Gloucester County Medical Society**

15 **Morris County Medical Society**

15 **Burlington County Memorial Hospital**
Mount Holly
Management of Exogenous Obesity

20 **Warren County Medical Society**

21 **Academy of Medicine of New Jersey**
Yale—New Haven Medical Center
New Haven, Connecticut
Endocrinology

21 **Academy of Medicine of New Jersey**
Saint Michael's Medical Center, Newark
Cardiovascular Workshop

22 **Burlington County Memorial Hospital**
Mount Holly
Hypercalcemia

29 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar

May

5, 12, 19 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

6 **Saint Barnabas Medical Center**
Livingston
Familia Toxemia

6 **Burlington County Memorial Hospital**
Mount Holly
Drug Abuse

13 **Burlington County Memorial Hospital**
Mount Holly
Management of Acute Drug Intoication

15 to 18 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

20 **Burlington County Memorial Hospital**
Mount Holly
Amniocentesis and Amnioinfusion in Pregnancy

27 **Burlington County Memorial Hospital**
Mount Holly
Breast Cancer

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OBITUARIES

Dr. Elizabeth M. Bogardus

At the untimely age of 46, Elizabeth Bogardus, M.D., died at the Bergen Pines Hospital in Paramus, where she was on the radiologic staff. Dr. Bogardus earned her M.D. at Long Island in 1949, did graduate work in both diagnostic and therapeutic radiology, and was board certified in her chosen specialty. She died on June 6, 1970.

Dr. Russell M. Coleman

Essex County residents will remember Russell M. Coleman, M.D., a well-known family doctor in the Orange area. Born in 1903, he was 67 at the time of his death on the first day of summer, 1970. Dr. Coleman was affiliated with the Orange Hospital Center, and during World War II was a major in the medical corps of the Army of the United States. He was awarded his M.D. from Howard University in 1933.

Dr. Francis J. Cronin

One of the attending surgeons at the Alexian Brothers Hospital in Elizabeth, Francis J. Cronin, M.D., died on August 30, 1970. Dr. Cronin, born in 1908, was a 1931 graduate of the Medical School of Georgetown University. He was active in medical and civic affairs, and in committee work of the Union County Medical Society.

Dr. William G. Fisher

William G. Fisher, M.D., a graduate of the Medical School in Dublin, Ireland (class of 1958), died on July 12, 1970 at the age of 45. He was a general practitioner with offices in East Orange and Newark, and was active in civic affairs in both municipalities.

Dr. Oscar E. Goldstein

An active Passaic internist, Oscar E. Goldstein, M.D., died on August 22, 1970. Dr. Goldstein was born in 1916 and earned his M.D. at Cornell in 1941. He was a Fellow of the American College of Physicians, on the staff at both Beth Israel and Passaic General Hospitals, and was board certified in internal medicine.

Dr. Joseph M. Gutowski

One of the senior members of our Middlesex County Medical Society, Joseph Gutowski, M.D., died on July 29, 1970, at the age of 74. He received his M.D. at the Medical School of the University of Maryland in 1923. Dr. Gutowski was a surgeon and a Fellow of the American College of Surgeons. He was on the staff at the Perth Amboy General Hospital.

Dr. J. Joseph Jacobson

On July 12, 1970, Dr. J. Joseph Jacobson of Atlantic City died after a brief illness. Born in 1900, he was a 1930 alumnus of Hahnemann Medical College. Dr. Jacobson was a general practitioner with special skill and interest in cardiology and, in that field, he was on the staff of the Atlantic City Hospital. He was active in committee work in our Atlantic County Medical Society.

Dr. Willard H. Lemmerz

One of Bergen County's best-known citizens, Willard H. Lemmerz, M.D., died on August 31, 1970. Dr. Lemmerz was a 1936 graduate of New York Medical College. He was a general practitioner with special interest in internal medicine, and was attending in medicine at both the Hasbrouck Heights and Hackensack Hospitals. At various times Dr. Lemmerz served as police surgeon, fire surgeon, and school physician in Wood Bridge. During World War II, he was on active duty with the Navy as Lieutenant Commander.

Dr. Stanislav A. Norkin

On July 25, 1970, a sudden and massive subarachnoid hemorrhage took the life of Stanislav A. Norkin, M.D., a well-known Monmouth County pathologist. Born in Europe in 1927, he did his premedical work in Germany, and came to this country in 1949. He was admitted to the medical school at

Harvard University, from which he was graduated in 1957. He was board-certified in pathology and was Associate Professor of Pathology at the Woman's Medical College. Dr. Norkin was active in the affairs of the American Society for Experimental Pathology, and was affiliated with the Monmouth Medical Center in Long Branch.

Dr. Martin H. Perle

A well-known Hudson-Bergen County orthopedic surgeon Martin H. Perle, M.D., died on July 26, 1970 at the too-young age of 44. Dr. Perle was in the class of 1949 at the Medical School of the University of Indiana. He was a board diplomate in orthopedics, a Fellow of the American College of Surgeons, and identified with the Medical Center and the Christ Hospital in Jersey City, with the Englewood Hospital in Englewood, and with the North Hudson Hospital in Weehawken.

Dr. Edward Pickert

The Director of the Pediatric Allergy Clinic at the Muhlenberg Hospital in Plainfield, Edward Pickert, M.D., died on July 3,1970. He was a 1940 graduate of the Medical School of Temple University, board certified in internal medicine, and chief of allergy at the Irvington General Hospital. Dr. Pickert was only 54 years old at the time of his death.

Dr. Robert L. Rehermann

A young, but well-known south Jersey pediatrician, Robert L. Rehermann, M.D., died on August 24, 1970, at the age of 47. He was a 1948 graduate of Georgetown Medical College, board certified in pediatrics, and on the staffs of both the West Jersey and Our Lady of Lourdes Hospitals in Camden.

Dr. Albert B. Rosenberg

Word has just been received of the death, on June 28, 1970, of Albert B. Rosenberg, M.D. Dr. Rosenberg had been, for some years, an emeritus member of the Hudson County Medical Society. He was an internist, with special interest in pulmonary disease. He was graduated in 1923 from the Chicago College of Medicine. Dr. Rosenberg was retired and living in Somerset County at the time of his death at the age of 71.

Dr. William C. Rucker

Active in the affairs of the New Jersey Society of Industrial Medicine, William C. Rucker, M.D., of Hackensack, died on July 27, 1970, at the age of 67. He was an attending orthopedist at the Hackensack Hospital, and was a 1931 graduate of the Medical School of Tufts University.

Dr. Antonio Rueda

A urologic surgeon, active in our Passaic County Medical Society, Antonio Rueda, M.D., died on August 19, 1970 at the age of 45. He was an alumnus of the Medical School at the University of Colombia in Bogota, South America (class of 1948).

Dr. Ned Shaw

One of south Jersey's leading ophthalmologists, Ned Shaw, M.D., died on July 23, 1970, while on vacation in the Bahamas. Born in 1910, he received his M.D. degree in 1936 at the University of Berne in Switzerland. He became board-certified in ophthalmologic surgery and was on the staff of the Cooper Hospital in Camden.

Dr. Chilton Spurgeon

After a long illness, Chilton Spurgeon, M.D. died on June 10, 1970 at the age of 59. Dr. Spurgeon did laboratory medicine until he became disabled by his illness in 1962. He was a 1936 graduate of the Medical School at the University of Chicago, and was active in the affairs of our Sussex County Medical Society.

Dr. Elaine Weston

A member of our Hudson County Component Society, Elaine Weston, M.D., a Kearny and Arlington general practitioner, died on February 22, 1970. She was a 1942 graduate of New York Medical College. Dr. Weston was only 54 years old at the time of her death.

BOOK REVIEWS

Alcohol and the Impaired Driver. Prepared by the Committee on MedicoLegal Problems of the American Medical Association. Chicago, 1968, the American Medical Association. Pp. 234. Illustrated with charts, maps, tables and pictures. $(1.50).

Physicians in this country have not played the serious role in appraising the drunken driver that has been their duty in other parts of the western world. Most of the work is done by doctors on a part-time, often reluctant basis. But here is a remarkably compact guide-book on the subject. Included is a description of most of the devices available for measuring the alcohol content of breath, urine, and blood. The doctor is shown how the equipment is constructed, how it works, how to avoid erroneous readings. But there is more to this book than a how-to-do-it manual. It has interesting chapters on the pharmacology of alcoholism, on the effects of this toxin on driving ability, on measures for the control of drinking drivers and on legal aspects of medical testimony in these cases. New Jersey's judicial decisions on drunken driving and tests for alcoholism are also described. (Similar decisions are included for almost all states). This highly useful little book ought to be available for every police surgeon in the country and on the shelf of every physician interested in toxicology, forensic medicine, or traffic safety.

WILLIAM SCHRAM, M.D.

Modern Treatment: Treatment of Cardiac Arrhythmias. Noble O. Fowler, M.D., Editor. New York, 1970, Harper and Row. Pp. 237. Illustrated. ($20 per year, by subscription)

This book covers the field of cardiac arrhythmias more than completely. Every practical aspect of the treatment of this diverse group of abnormalities is described, illustrated, discussed, and tabulated in the first 96 pages. After this, the book broadens its format to include chapters on digitalis-induced arrhythmias, arrhythmias complicating acute myocardial infarction, the use of D.C. electroshock therapy, and propanolol usage. There is an entire section on cardiac resuscitation. The authors of each chapter have done their individual jobs so thoroughly that there are many examples of duplication as well as a few minor disagreements. For example: the indications and contraindications for electrical conversion of atrial fibrillation is found on pages 66 and 67 authored by Noble Fowler and again between pages 195 and 205 by Leonard Dreifus. This type of repetition appears on other subjects such as ventricular fibrillation treatment, use of propanolol, pacing procedures, and lidocaine therapy. More careful editing may have reduced this redundancy thereby improving the readability of the book.

The general material is good if one can overlook these minor defects. I can recommend it as a reference book for doctors who have a solid foundation in cardiology.

Manuel J. Rowen, M.D.

The Moment of Death. Edited by Arthur Winter, M.D. Springfield, Illinois, 1970, Thomas. Pp. 84 ($6)

No one has ever previously published a book like this. It is a study of the concept of the instant or moment of death and of the various indices we have developed to determine whether a person is still, in any sense, alive. This is a report of six experts, presented at a symposium in Nutley last year, and sponsored by the Academy of Medicine of New Jersey. This work is reviewed in more detail on page 652 of this issue of *The Journal.*

Henry A. Davidson, M.D.

Drugs on the College Campus. Helen Nowlis, Ph.D. Garden City, New York 1969, Doubleday. Paperback. Pp. 144. (95¢)

We face three kinds of drug dependence in the U.S.A. There is, first, the heroin-addicted slum dweller; then the barbiturate dependent middle and upper class person, most often female; and finally the college-age student. The Association of Student Personnel Administrators (with help from the FDA and the NIMH) held a "workshop" on the subject and this little book is a synthesis of the papers and discussions there.

The use of drugs on the campus arouses a kind of annoyance in most of us quite different from our sense of alienation from the heroin-user and from our tolerance of the barbiturate eater. What complicates it is, these reporters say, that students who use (or abuse) drugs are drawn from a kind of academic elite. The way it has spread in spite of harsh penalties makes one wonder about the effectiveness of the punitive approach. (We have tried it with hard core drugs, having set up in the USA the most drastic penalties for the peddling and possession of narcotics; and we now seem to have the highest rate of such addiction of any country in the western world.)

The topic is well discussed in these pages, and one of the conclusions — which will probably irritate most of us — is that adults take drugs (like alcohol and barbiturates) to blunt the pains of living and dull the harsh edge of reality. The students take their drugs in an effort (usually vain) to strike back at this pain and to seek insight into its causes. You may not agree with all the conclusions here presented, but this text will provoke your thinking on the subject if not always your agreement.

FELIX A. UCKO, M.D.

To Smoke Or Not To Smoke. Luther L. Terry, M.D. and Daniel Horn, Ph.D. New York, 1969, Lothrop, Lee, and Shepard. Pp. 64. Illustrated. ($3.75)

There are more over-the-counter sales of cigarettes alone than of any other manufactured product in the U.S.A. This slender book gives the background of the economic aspects of the tobacco industry, reviews what companies spend for advertising, and tells you where you can get additional reading on the subject. It is addressed primarily to literate young people. It discusses why people start smoking, why they keep it up, and how they can be helped to quit. The text does not talk down to its readers and does not preach at them. It tells them like it is—and it's not a pretty story. This is a volume that you can safely recommend to young people, and it also contains data and viewpoints helpful to any adult responsible for giving smokers the truth about the habit.

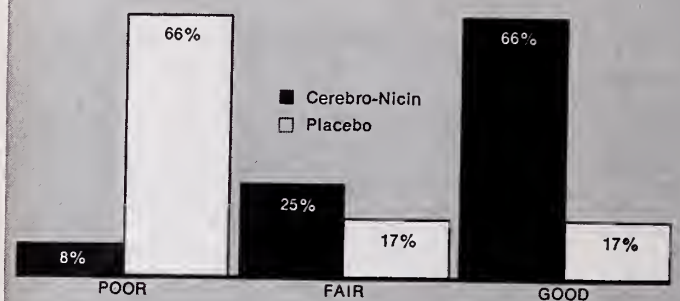
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References: 1. Montesano, P., and Evangelista, T. Methyltestosterone thyroid: treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dubin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Trieff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Nehmar, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K. and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Cotton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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1. Gordon, E.E. and Haas, A., Industr. Med. Surg. 28:217, May, 1959.

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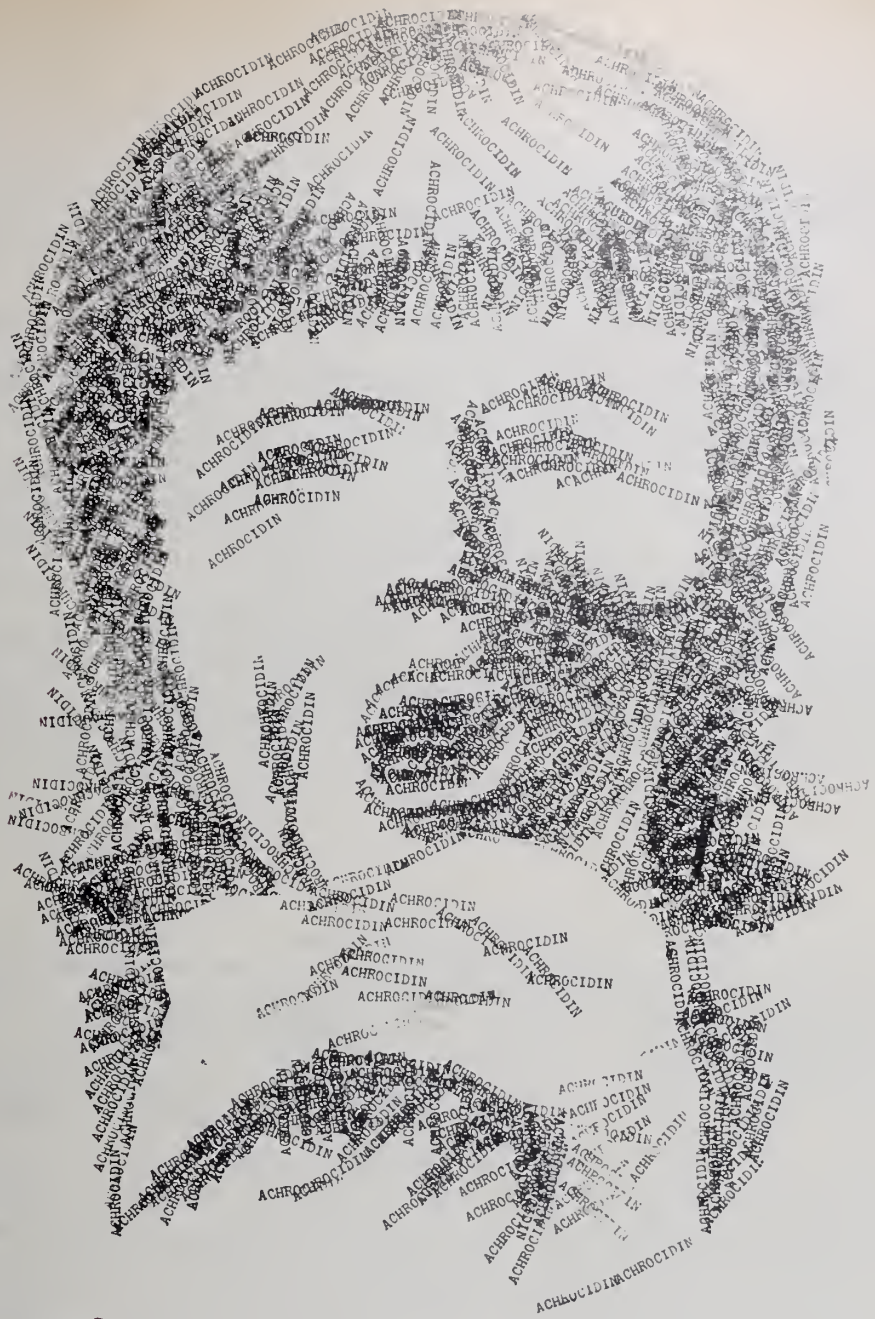
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NOVEMBER 1970
VOL. 67, NO. 11

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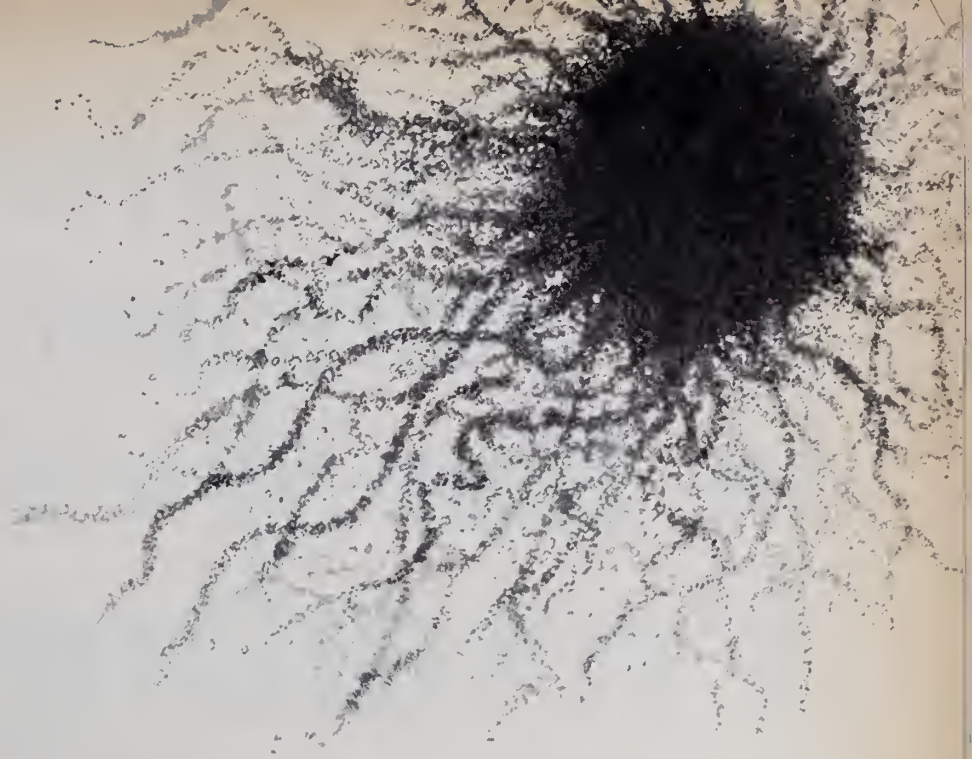
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Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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EDITORIALS

November Is Life Month

This is the tenth annual "Life Month" for our Medical Society's Life Insurance plan. More than 1,700 members participate in this plan. During the past year, 22 death claims were filed, bringing the total death benefit paid under the plan to more than $1,900,000 since inception. The plan has now been broadened so that a members' spouse, son, daughter, or employee could participate. Dependents and employees can apply for up to five $10,000 units, for a total of $50,000 of low cost term insurance. Spouses and employees must be under age 65 to apply and children must be between 15 and 21, or to age 26, if at school.

Each insured person will have an individual non-cancellable term life insurance policy at the extremely low cost. It is not necessary for a member to be insured in order for his dependents or employees to participate in the program. Members tell us that this new program has proved to be valuable for their sons or daughters of college age. Not only can the plan provide coverage during the school years, but it can be continued as a permanent part of the child's insurance program in later life. Once issued, *all* policies are renewable as term insurance to age 70 and guaranteed convertible at that time (or earlier).

Members, including those who choose to practice as professional corporations, have found the program valuable for use as employee benefit programs or as an extra privilege for their employees.

During this month members under age 65 are invited to apply for up to ten $10,000 units of term life insurance, including what they already carry under the program, making their maximum life insurance protection $100,000. All policies issued to members, spouses, dependent children, or employees have a guaranteed right of conversion without medical examination at any time regardless of health history or physical condition. All policies have double indemnity benefit and waiver of premium benefit without extra premium cost.

Diabetes Week – November 15 to 21

This is again the week designated by the American Diabetes Association as a reminder to the general population (particularly those in whose families diabetes is prevalent, obese individuals, and those over forty years of age) to have their blood and urine checked.

It is also a reminder to our members that the search for the disease is a year-round job and that no physical examination is complete without a urine examination. In the individuals mentioned above, a post-prandial blood sugar is also indicated. This is particularly important in older people because diabetes is an insidious disease and full-blown symptoms develop very slowly. Out of the diabetic population of four million in this country, half of them don't know that they harbor the disease.

At this time we should also take a stand in the controversial issue provoked at the 1970 meeting of the American Diabetes Association. One member asserted that those using an oral anti-diabetic over a period of years die earlier than those in the placebo group, or those treated with insulin.

The American Diabetes Association swiftly issued a statement declaring that at this point "the evidence presented does not appear to warrant abandoning the presently accepted methods of treating diabetes with the diet, anti-diabetic agents, or diet with insulin, as indicated." The Food and Drug Administration feels that the study findings *against* sulfonylureas are still *"not proved."* The Canadian Food and Drug Directives also consider the findings inconclusive. In London, the

Committee on Safety of Drugs declared that no action will be taken in that matter.

In view of these divergent opinions, we feel that no drastic action is indicated at the present time and patients should be reassured about the safety of the oral drugs.

Twentieth Century Quackery

Look through the lurid and sensational quackery of the nineteenth century. It may make you smile at the credulity of our ancestors. Can any one really believe that magical pain extractors would uproot pain, that magnetic oil would "cure" rheumatism, that Redwig's Mexican Joy Herbs would eliminate the symptoms and basic causes of twelve different diseases? How could a successful, prosperous, shrewd people — capable of building an empire — how could such a people fall for the errent nonsense of these quacks? We are much smarter now in the twentieth century.

But are we? There were Indian snake root peddlers a century ago. We have a new Indian snake root now — Asiatic Indian though, not American Indian. (That's the serpent in *Rauwolfia serpentina*). We have diet fads galore, and many a man who should know better rides a hobby to death. A book on folk medicine not so long ago was on the best seller list, though it seems incredible that anyone could have honestly believed that a mixture of two simple ingredients could have been such a panacea. We have had dianoetics and Bridey Murphy, and a heart-breaking parade of cancer cures. Any night on television you can see simple medications portrayed as miracle drugs, with anatomic and physiologic sketches that make up in luridness what they lack in accuracy. Quackery is always with us, and we are, basically, no smarter than our grandparents. We may be more cynical, more skeptical, and less concerned with such old-fashioned qualities as honor and morality. But we still want so much to believe that we will rationalize anything that fits our emotional needs or our dearest wishes. The fight against charlatanry has always been one of organized medicine's noblest claims to public confidence. The battle against quackery is not over. And as with all battles, eternal vigilance is needed.

Index Of Suspicion

It is, one admits, a stereotyped phrase: index of suspicion. Yet the doctor who maintains a high i.o.s. will be less likely to get into difficulties than the one who assumes that all patients are disease-free and all complaints are hypochondriacal. It is a common charge that the doctor of medicine tends to be "disease oriented" rather than "patient oriented." What is meant is that the doctor's first reaction to a medical complaint is: "What diseases can cause this symptom?" Whereas, it might be better if he asked himself: "What kind of difficulties would this manner of man have?" This may be true, but as a practical matter the practitioner, whether in his office or at the bedside, can better serve his patient if he wonders first about the morbid organic processes that might cause the symptoms. It is admittedly, unfortunate to treat a patient for a non-existent illness, to suggest directly or by implication that the patient may have heart disease or cancer when, in fact, what he has is a hysterical conversion reaction. It is true that we can create a kind of iatrogenic illness by speaking and acting as if our patient had a grave disability. It is also true that an apparently endless round of laboratory and x-ray procedures may impress on the patient the idea of sickness, and that may cause harm.

This is all true. But in practice, the consequences of missing up on an organic diagnosis are likely to be more serious than the consequences of assuming that the symptoms are without an organic basis. Being human, we must sometimes err. It seems safer to err on the side of suspecting organic disease, rather than err by lightly dismissing medical complaints and "slightly positive findings." So, even if it is an overworked cliche, a high "index of suspicion" may be a good thing to have.

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ORIGINAL ARTICLES

Apparently no one, no matter how defective, has to be abandoned and left to vegetate. Here is a remarkable example of what can be done with patience, training, and motivation.

Rehabilitation Of A Multi-handicapped Institutionalized Child*

Helena W. Temmer, Ph.D. and Susan Kraut, M.A./Princeton

The adverse effects of institutional placement on the development of normal young children has been pointed out by many researchers.[3,4,6,7] Spitz's well-known work on "hospitalism" demonstrated that lack of motherly care can result in physical damage to the infant in spite of favorable hygienic conditions, while reinstatement of such care can reverse the deterioration. Spitz's conclusions have been supported by further research.[1,2,3] Provence and Lipton[6] tried to supplement some of Spitz's lacks by defining the populations involved and by careful longitudinal retesting of the subjects, both institutionalized and reared in families. Unfortunately, the value of this painstaking study is limited by the exclusion of numerical data. While Spitz's institutionalized infants[1,2] suffered the loss of a mother, or mother-substitute, those of Provence and Lipton[6] had never had individual care. Nevertheless, the developmental anomalies which appeared were in many ways similar for both groups. This suggests a common factor of deficiency in individual care, rather than necessarily one of loss.

The nutritional status of young children as it affects the development of intelligence has been receiving increasing attention. Eichenwald and Fry[9] point out that neurological inadequacies resulting from protein and calorie deficiency may persist even after physical growth has resumed. Total losses are not compensated entirely, but remain in various subtle traces in the organism, such as impairment of learning ability and disturbed behavior.

The current study deals with the combined effects of congenital damage, long-term malnutrition, and environmental deprivation in a multi-handicapped child somewhat older than the subjects of Spitz and of Provence and Lipton.

* This work is from the New Jersey Neuropsychiatric Institute at Princeton, in cooperation with the Trenton Division of the New Jersey Bureau of Children's Services. In addition to the two listed authors, many colleagues contributed to this study by their judgment and encouragement. The authors owe a particular debt of gratitude to Henry B. Murphree, M.D. who graciously served as an informal consultant concerning the medical aspects of Paul's training and management; to Ruth Zager, M.D. who generously gave of her time in examining the medical records, interpreting them, and giving invaluable advice during the writing of the study; to Cyril M. Franks, Ph.D. whose acumen and experience were freely drawn upon in preparing the manuscript; and to each of them for their criticisms and suggestions. Copies of illustrative graphs and other materials may be obtained on request from Dr. Temmer, New Jersey Neuropsychiatric Institute, Box 1000, Princeton 08540.

Paul was released by his unmarried mother for adoption at birth in the care of a public agency. He was placed in an institution shortly after birth when he was diagnosed as suffering from a patent ductus arteriosus with left to right shunt plus bilateral cataracts. It was also felt that he was partly or totally deaf. A congenital rubella syndrome was suspected on the basis of the mother's report of a rash in the first trimester of pregnancy. (This was confirmed by viral studies when the child was almost 5 years old.) Paul was referred for study with the question as to whether he would "have a normal childhood if his physical disabilities can be helped through operations." He was then three years old. He underwent the removal of his right cataract at one year, and of his left one at two years. Glasses were not provided until he was three years old. The child appeared to make little use of vision, except to turn his head toward the light. A screening evaluation at a camp for the blind was held at the age of 2½ but the recommendations were not followed. Nothing special was done for Paul until the psychological testing. His environment was one of extreme monotony, with a minimum of attention from a limited and overworked staff, no individual stimulation, play, or outdoor outings. He could be described as merely vegetating. Paul was emaciated, due to his refusal to eat. His weight was 17 lbs. 12 ozs., his height 35 inches. The operation which was expected to restore his functions to normal kept being postponed, because of his precarious state of health. He seemed destined to die or to lead an entirely passive institutional existence, unless some remedial means were immediately instituted.

The child's behavior repertoire was too meager for a complete psychological evaluation. It was estimated that he functioned at levels between 12 and 40 weeks. The Vineland Scale yielded an Age Equivalent of .53, Social Quotient of 17. Autistic mannerisms were noted by the examiner and reported by the nurse (finger motions, pushing and slapping at his eyeballs, smearing feces). Similar behavior patterns are frequently reported for institutionalized infants.[6] There was no locomotion. On the assets side, Paul appeared to enjoy physical contact and to seek it at times. He could sit and push himself around in supine position. He could be induced to manipulate simple testing materials with apparent pleasure. In spite of his limitations, he impressed attendants as a lovable child. All physical findings, except those mentioned above were negative. The physician who was a consultant to the institution saw no contraindication to a program of mild exercise and stimulation.

Since the institution could not provide individual care and no foster-home was willing to accept a severely handicapped youngster at that time, the junior author volunteered to work with Paul regularly, in frequent consultation with the psychologist. The report on the course and results of that program constitute the body of this study.

Our objective was to counteract physical and emotional effects of institutionalization and neglect in a young multi-handicapped child by means of especially adapted technics of stimulation and training. We visited Paul frequently and an attempt was made to enlarge his field of experience, to stimulate his appetite by physical exercise and to change the feeding situation from a passively endured ordeal to a pleasant participatory experience. Since food could not be used as a reward, other kinds of stimulation had to be found, primarily tactile and kinesthetic ones, leading eventually to social responsiveness and affective relationships. In applying behavior modification methods, the child's special limitations were taken into account. Modeling was used in encouraging locomotion and self-feeding with a spoon. Emerging new patterns of behavior, whether spontaneous or in response to training, were recorded at each session in detail, and further training was modified in the light of appearing possibilities. Thus it developed that a flashlight could be used as a reward and as a motivating agent in developing locomotion; it also served as an instrument of social interaction, the child indicating by gestures that he wished it to be turned on. Paul's responsiveness to

being held was utilized in establishing social and affective bonds; hugging, stroking, rocking and the like were used as rewards for achievement. Paul indicated his enjoyment by smiling and laughing. Smiling became a spontaneous reaction to human approaches. He was taught simple interactional games such as light mutual hitting or clapping hands. Feeding sessions were held, using the most acceptable foods; the nurse was urged to use diversity and home cooked foods, rather than the commercial baby foods served mixed together. This was the area of greatest resistance to modification and subject to variability with summer heat and fatigue. Nevertheless, beginnings in self-feeding were made by having Paul hold his spoon in the worker's grasp and guiding it to his mouth. The same method was continued by the foster-mother.

Sensory function was fostered by the use of glasses, received after a month of training, but probably never worn outside of the sessions. Paul would remove them, unless they were tied on. The recommended hearing aid was not available during the training or the placement period. (It is about to be provided now.) Paul made some response to noisy toys, but the extent of auditory stimulation received was doubtful.

The personnel of the institution enlarged by summer volunteers also used the stimulating and training technics, thus providing some continuity. Since Paul had now much more appeal and interest for the staff and visitors, he became the favorite of several adults and thus received increased stimulation.

A screening examination given when he was 2½ indicated approximately the same primitive patterns of function as noted during the first test. It seemed that the boy's physical and behavioral development were both at a virtual standstill for about one year before the first examination.††

In view of his meager repertoire, Paul's behavior was grouped under three headings, using Gesell's categories as guides: (a) motor (including posture, locomotion, manipulation), (b) personal-social and adaptive (searching for a person, approaching, playing with a toy, self-feeding), and (c) vocalization (any kind of sound except crying or laughing). The first two behavior categories began to appear as soon as training was introduced and continued on a roughly parallel course, while the vocalization showed no change until after foster-home placement.

Motor items range from 18 to 40 weeks in the first week of training; from 48 to 52 weeks five months after the placement in a foster home; and from 12 to 18 months 11 months after placement. The initial ratings for the personal-social and adaptive items include a range from 12 to 40 weeks, while the terminal ones show a range from 12 to 18 months.

In spite of Paul's highly atypical development, the sequence of acquired skills is similar to that occurring in normal infants. Thus, after the age of 2½, only small fluctuations of weight occurred, while growth continued in length. As soon as the program was introduced, at 3½, a gain in weight began and continued until the end of the training period, with one "dip." A sharp increase followed foster-home placement. In all, Paul's weight rose from 17 pounds, 12 ounces to 29 pounds during a 17 months period, a gain of 62 per cent. This reflected the child's increased appetite and his generally improved physical status which enabled him to undergo the successful corrective heart surgery 5 months after foster-home placement. Independent walking (15 months level) appeared about 6 weeks after the surgery, while other functions, including appetite, showed steady growth since foster-home placement.

Paul's weight curve veers away progressively from the lowest percentile curve, while the other growth curves maintain roughly a parallel course. This illustrates Paul's area of greatest physical retardation. His physical improvement shown by his weight gain, and his be-

‡The sources of information throughout the study are the files of the respective institutions and agencies who took care of the child and treated him. Their courtesy and cooperation is hereby gratefully acknowledged.

havioral development reflected in the psychological profiles suggests a certain parallel between the two processes.** At the age of 39 months, when training was started, his behavior approximated that of a 40 weeks old infant, and his weight (17 pounds, 12 ounces) was also compatible with that age.

Paul was operated on for cataracts at 14 months and at 28 months. He received eyeglasses at 3 years of age, but did not wear them regularly and showed no apparent improvement in vision during the training period. However, the post-placement testing indicated a much more direct and deliberate approach to objects, even to small ones, without the glasses. This suggests that increased experience and motivation in exploring the environment, rather than the removal of cataracts or the use of glasses *per se* tend to improve visual function. Auditory responsiveness continued to be very limited and erratic.

Paul continued to function within a severely retarded range, but his behavior was sufficiently organized to permit the administration of the Cattell Scale which reflected an IQ of 20. Self-injurious behavior has markedly decreased in frequency and intensity. Fecal smearing has ceased altogether. Toilet training resulted in almost complete bowel and bladder control. He could feed himself independently.

Conclusions

This study points out the intricate relationships between a human organism's experience, his physical status, and the resulting functioning in various areas of behavior. Emotional and environmental deprivation of a congenitally handicapped child can impair his originally limited functioning to an extent where remedial physical means become either ineffective or impossible to apply. Conversely, psychological training and affective satisfaction can bring about measurable physical improvement which can lift even a severely handicapped child to a higher level of achievement and bring him within the reach of therapeutic medical procedures. This effect has been demonstrated in the present case within an institutional setting, with limited time and means. Twenty-four hour care and stimulation available in a family setting bring about even more marked and rapid improvement. One may speculate that analogous methods of rehabilitation can produce favorable results with mentally normal, but physically handicapped or emotionally disturbed children who acquire the syndrome of "pseudo-retardation" due to various inadequacies of stimulation. Preventive work might forestall the establishment of "autistic" or "autistic-like" behavior patterns which in the current case appeared to result from lack of stimulation rather than from withdrawal. It seems possible to view such patterns as responses of a handicapped or environmentally deprived individual to a situation with which he cannot cope. If this is the case, autistic behavior patterns can be considered a reversible and variable syndrome occurring in a variety of circumstances, rather than all-or-none manifestations of a specific disorder.

Considering our case-study in the light of previous findings, a few tentative conclusions may be drawn. The institution in which Paul was raised approximates in general outlines Spitz's Foundling Home, Dennis' and Najarian's Creche, and Provence and Lipton's Institution. Whether one refers to this type of environmental setting in the more elusive psychodynamic terms of maternal deprivation or in the more concrete and quantifiable ones of sensory and learning deprivation, the risks to the institutionalized infant are considerable. The normal baby tends to function at a defective or borderline level, the retarded baby at a vegetative level. The example of Paul does not permit any conclusions as to the long-term effects or reversibility of the damage, but at least some of the measurable deficiencies appear susceptible to improvement within a short time. This points the way toward the improvement of infants' institutions, and their use as a last resort and for short-term care only.

** The authors are indebted for this observation to Ruth Zager, M.D.

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Noise As The Third Pollutant

Jets, jackhammers, sirens, food blenders, electronic music—all contribute to making the sound of our cities almost unbearable. At home, at work, at play, innumerable pieces of equipment add to efficiency and convenience—and threaten us with the jitters and with loss of hearing.

Noise—The Third Pollution, a new Public Affairs Pamphlet, by Theodore Berland, explains what noise is and what it does—physically and emotionally. The pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York 10016.

"Noise is sound that is obnoxious. Noise travels like waves on water, but invisibly. It is usually carried by air, but it can also be conducted by the wood walls of homes, by the steel floors of offices, by the glass in windows, and by the metal bodies of autos and airplanes. If the noise is loud enough, the ear can suffer temporary inability to hear. If the cells are given a rest, they can recover. But they can't if the noise is too prolonged or repeats itself too soon."

Sirens and jet engines and high amplified rock music are examples of noise which is most dangerous to hearing and which, today, few persons can fully avoid. They exemplify what noise researchers have found: that many noise levels encountered in the community exceed standards found injurious in industry. Even the unborn child in its mother's womb suffers stress because of noise, "which may induce developmental abnormalities in the fetus. Noise increases the level of cholesterol in the blood and raises blood pressure."

The emotional effects of noise are centered on fear and annoyance. A man who works in a frustratingly noisy environment comes home irritable. If his home is also noisy, he not only is not a pleasant person to be with but his mental health is actually threatened. Incidentally, noise can cause cracks in metal, break glass windows, crack plaster walls, and destroy irreplaceable archeologic specimens.

But we can protect ourselves against noise and its hazards. Berland suggests that you cover your ears with your hands, or with ear plugs when noise becomes unbearable. He even recommends that "each of us carries a pocket set of ear plugs or ear protectors."

The United States lags behind other countries on control of noise because we have no national anti-noise legislation. And the state and local regulations that do exist are only weakly enforced. When citizens organize themselves and make their wants known, government, business, and industry must listen. It has happened in the area of pure foods, and in auto safety, and it is happening in air pollution and water pollution. If more citizens make noise about noise, this too will be actively and successfully fought.

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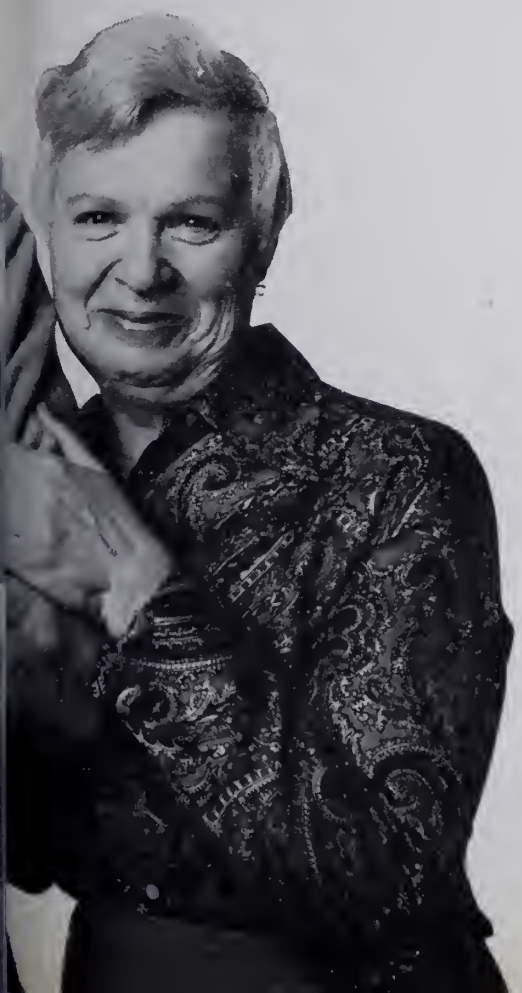


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His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactating or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

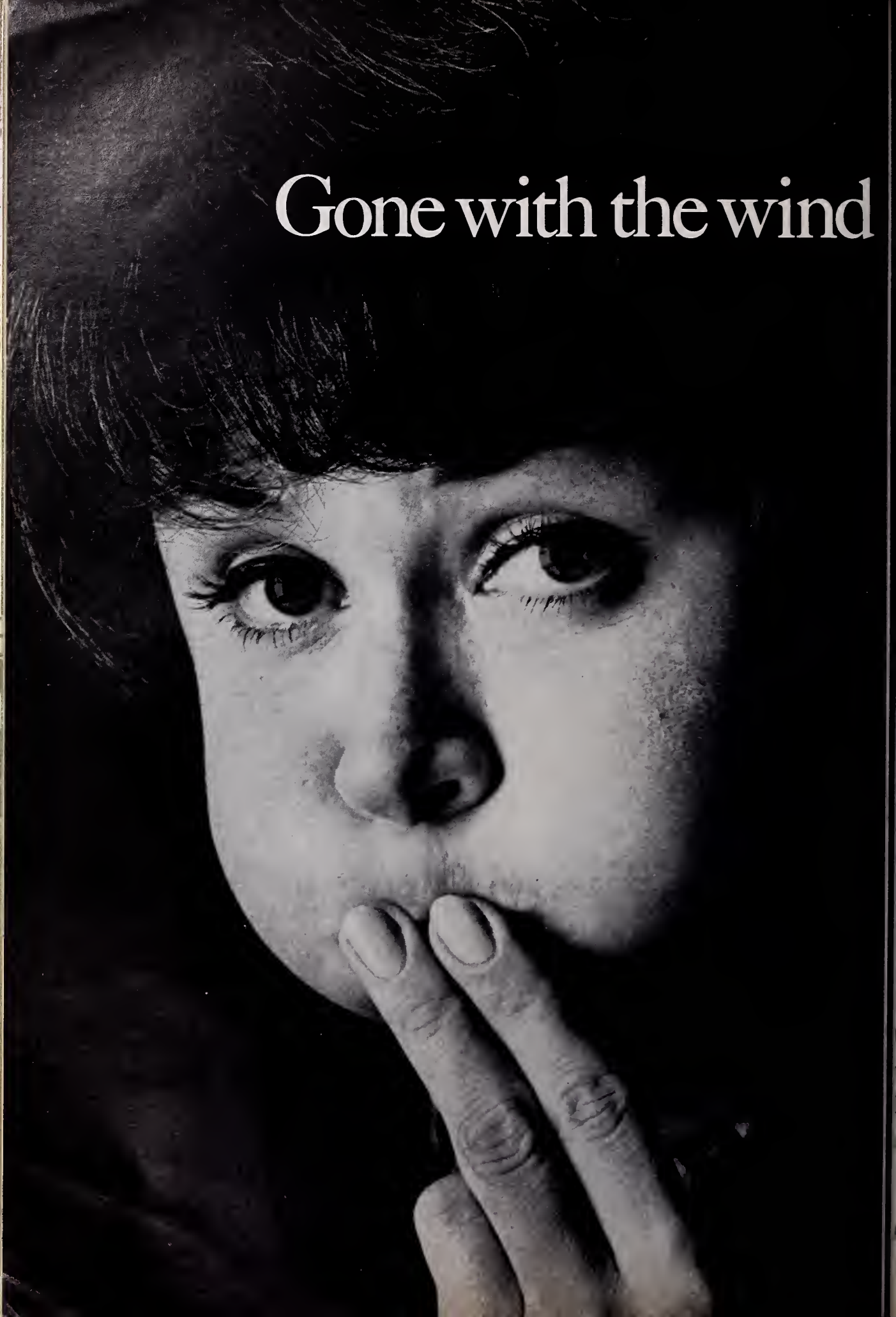
Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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Roche announces

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for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

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Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

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In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



2/2/68—After 11 days of treatment. Erythema is seen at site of keratoses. In addition, numerous lesions not apparent prior to therapy have become manifest by sharply defined reactions. Intervening skin, also treated, shows no response to therapy.

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Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

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Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning the site of application. Other local reactions included dermatit scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scalin swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice da with a nonmetal applicator or suitable glove in an amount of th solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequer erythema, usually followed by vesiculation, erosion, ulceration necrosis and epithelization. The lower frequency and intensity activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammator reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of th lesion may not be evident for 1 to 2 months following cessation c Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—contain 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions whe complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or mor was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 177 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

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The trans-thoracic approach to splenectomy here appears to be better than the usual trans-abdominal route.

Aneurysm Of The Splenic Artery

**Adrian M. Sabety, M.D.,
Franklyn P. Gerard, M.D., and
John S. Madaras, Jr., M.D./East Orange**

Next to the aorta, the splenic artery is the most common site of aneurysmal dilatation in the vascular system of the abdominal cavity. Since the first description by Beaussier in 1870, more than 300 cases of splenic artery aneurysm have been reported in the world literature.[1] The true incidence, however, is unknown. Among 58,000 autopsies studied, Seids and Houser[2] have reported an incidence of 0.05 per cent of aneurysm of the splenic artery. In contrast, when routine arteriographic study of 250 necropsy cases at a geriatric hospital was done by Bedford and Lodge[3] the incidence of aneurysm of the splenic artery was found to be 10.4 per cent. This finding is significant in the light of the present trend in longevity, and the increasing number of contrast studies of the arterial vascular system now being done. It is, therefore, with increasing frequency that we will be faced with the problem of deciding the correct management of a patient who is symptom-free except for the aneurysm of the splenic artery. Here presented are two such cases.

Case One

This 68 year old man was admitted to the Hospital Center at Orange with the diagnosis of possible aneurysm of his splenic artery. Several weeks prior to this admission, he had consulted his family physician for a back pain secondary to a chronic arthritis of the spine. At x-ray, a round calcified structure was discovered in the left upper quadrant of his abdomen. This mass was interpreted as consistent with the diagnosis of aneurysm of the splenic artery. The history was unremarkable except for an accidental fall from a short ladder three years prior to admission. Routine laboratory work was found to be within normal limits. Celiac arteriography (Figure 1) demonstrated an aneurysmal dilatation of the splenic artery measuring about 3.5 by 7 centimeters. It contained calcifications and clots. Other branches of the coeliac artery were entirely

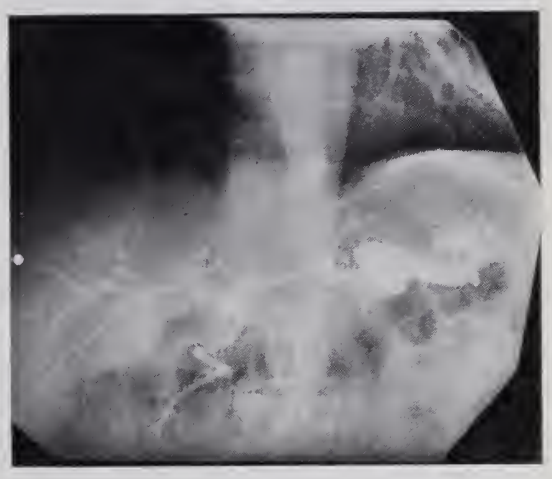


Figure 1

within normal limits. Intravenous pyelogram showed no abnormality.

The aneurysm was removed by a trans-thoracic splenectomy. His post-operative course was uneventful. He was ambulatory on the second post-operative day and discharged on the ninth post-operative day. Pathological examination of the specimen (Figure 2) showed the splenic artery to contain a large arteriosclerotic aneurysmal sac about a centimeter distal to its cut end.

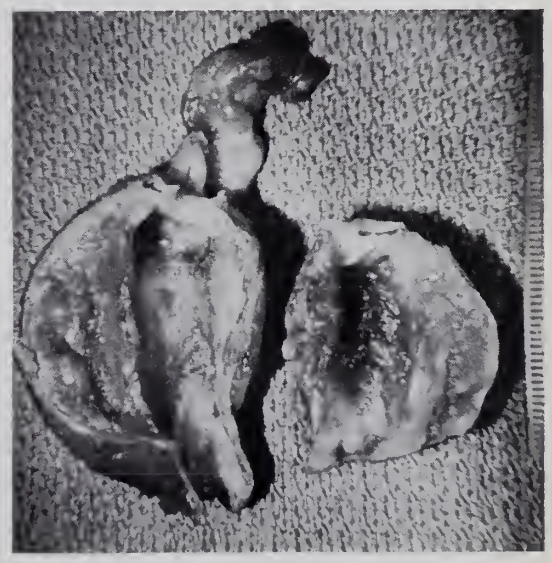


Figure 2

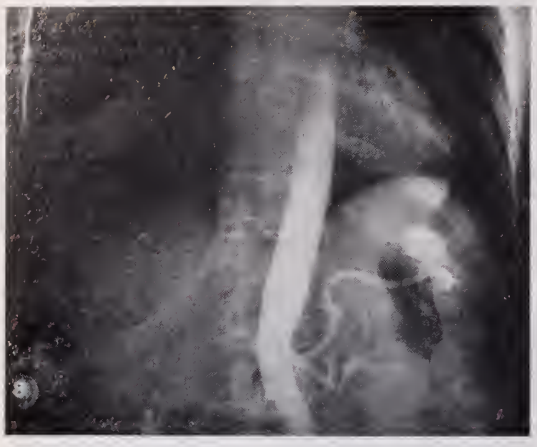


Figure 3

The aneurysm measured 7 centimeters in diameter and contained a number of clots. Rest of the examination of the specimen was unremarkable.

Case Two

This 59-year-old female was admitted to the Hospital Center at Orange with vague abdominal symptoms. The only positive finding was x-ray demonstration of an area of calcification in the left-upper-quadrant of the abdomen. A celiac arteriogram (Figure 3) demonstrated an aneurysm of the splenic artery measuring about 3 centimeters in diameter. Splenectomy was done with removal of the aneurysm. Her post-operative-course was uneventful. The patient was discharged on the tenth post-operative day.

Examination of the specimen showed an arteriosclerotic aneurysm of the splenic artery measuring about five centimeters in diameter. It was located about one centimeter distal to the line of severence of the artery.

Prior to rupture, the splenic artery aneurysm offers no detectable symptom. This artery is located in a rather mobile structure. For it to cause symptoms of compression, it is necessary that the aneurysm become enormously large and this is seldom observed. On the other hand once the aneurysm is ruptured, an incidence reported to be 33 to 46 per cent,[4] the signs are those of an acute condition in the abdomen with left upper quadrant tenderness, generalized abdominal rigidity and distention, hypoactive peristalsis complicated by a state of shock and gradually decreasing blood volume. Symptoms of massive gastro-intestinal hemorrhage prevail if the aneurysm erodes into the gastro-intestinal tract.[5] In such cases, the correct pre-operative diagnosis is seldom made except in an unusual set of circumstances, where time and facilities are available, the index of suspicion is great, and the patient's condition permits a celiac arteriogram.[6] In the usual situation, however, the patient is explored with a tentative diagnosis of an acute and massive intra-abdominal hemorrhage. Unfortunately, the correct diagnosis may not readily be apparent even at the time of exploration, because of the extensive extravasation of the blood in tissues causing confusion, delay in control of bleeding, and high operative mortality and morbidity.[7] In the elective cases, in contrast, the diagnosis is always absolute and well documented by appropriate arteriographic studies. The two cases reported above fall into this category.

Surgical Technic

In the treatment of elective cases of aneurysm of splenic artery, a trans-thoracic approach to the aneurysm is a preferable method in view of ease of performance, excellence of exposure, and absence of complications.

The patient is placed on the operating room table in a right lateral decubitus position. The left pleural cavity is entered through the bed of the 7th rib. The lung is retracted upward. The diaphragm is exposed and incised radially over the spleen. With the diaphragm open, the gastro-splenic ligament is the first structure which presents itself. This is cut between clamps and the hilar structure of the spleen is thus fully exposed. The ease of exposure (without the usual forceful, multiple retractions necessary in trans-abdominal approach) is quite remarkable. The aneurysm is easily located and excised together with the spleen. The diaphragm is closed with continuous uninterrupted non-absorbable suture material. A single chest tube is inserted in the pleural cavity and connected to a water seal system, and the chest is closed. The chest tube is removed as soon as the lung is fully expanded, which takes only a few hours; and the patient is ambulatory the next day; ready to be discharged within the week.

The ease of the operation and the excellence of the exposure by a trans-thoracic approach

to the spleen is not surprising, when one considers the fact that the spleen is normally located within the thoracic cage. If splenectomy is not routinely performed through the thoracic approach, perhaps it is due more to surgical tradition than to anatomical necessity.

Summary

1. Two cases of aneurysm of the splenic artery surgically removed are reported.

2. The advantages of prophylactic excision of the aneurysm of the splenic artery are discussed.

3. In the elective cases, trans-thoracic approach to the aneurysm of the splenic artery is a superior method.

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Rapid Induction of Heart Disease

Albany Medical College reports that their research team has developed a method for the rapid induction in animals of advanced coronary heart disease strikingly similar to that occurring naturally in man. The induced disease produces such clinical manifestations as heart attacks and sudden death in the animals.

This work, supported under a research contract from the National Heart and Lung Institute, promises to fill a need that has long hampered research on acute heart attacks and other potentially lethal consequences of coronary heart disease: the lack of a suitable animal model.

Heart attacks almost never occur spontaneously in most animals. Methods have fallen far short of duplicating closely in animals the heart-muscle damage, circulatory alterations, physiologic consequences, and potential complications that result from advanced coronary disease and acute heart attacks in man. This has vitiated the value of data gained from animal studies on acute heart attacks and has made questionable the extrapolation of their findings to clinical situations.

In the Albany program, the animals were fed a semisynthetic cholesterol diet to raise blood-lipid levels. These blood lipid levels were driven still higher by lacing the diet with propylthiouracil. Excessive quantities of calciferol, a vitamin D derivative, were added to the diet to raise blood calcium levels.

Then, after the animals had been on this diet for a time, their coronary arteries were irradiated with tissue-damaging doses of x-rays to facilitate the invasion of the artery walls by lipids from the blood.

Animals subjected to this regimen characteristically developed advanced coronary atherosclerosis within two months and an extremely high incidence of heart attacks and sudden cardiac death shortly thereafter. Autopsy studies indicated that the arterial lesions resembled those of advanced coronary heart disease in man; and the heart damage resulting from the induced heart attacks was similar in extent, severity, and location, to that frequently encountered in clinical cases.

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Something beyond an understanding of "human plumbing" is required in modern sex education.

Sexual Ignorance*

Gerald S. Barad, M.D./Flemington

At a time when sex education of young people and adults is a major national issue being discussed from the dining room to the public meeting, to the legislative halls of our states, it is well to review the target of such education: sexual ignorance. It has been said that we are presently witnessing a sexual revolution. It is probably more likely that we have been involved for many years in a process of sexual evolution. This has moved slowly in the past, but with the monumental work of such leaders as Freud, Kinsey, and Masters and Johnson, information on human sexual behavior and sexual function is becoming available.

When we look back at the attitudes of our own profession only a little over one hundred years ago, the distance traveled becomes more evident. James Marian Sims published "Clinical Notes on Uterine Surgery" in 1866. A review of this book in the *Medical Times and Gazette* gives us insight into the attitudes of his colleagues at that time. "With regard to the discovery of the total expulsion of the fertilizing fluid from the vagina, and to the dabblings in that canal with speculum and syringe under the circumstances described, we can but express our unfeigned regret that Dr. Sims has thought proper to found an odious style of practice on such impure an assumption. At any rate, if such practices were to be considered the 'business of the physician,' then a good many of us would quit Physic for some other calling that would let us keep our sense of decency and self-respect. Better let ancient families become extinct than keep up the succession by such means."[1] The attitude of physicians toward the role of the woman as a sexual partner can be seen in the words of a gynecologist of that period when he said, "Any wife who shows any pleasure in intercourse is no better than a prostitute." Although the attitudes in the 1930's were certainly far less repressive, it is of interest to note that Starling's *Physiology* in 1936 stated, "The essential features of fertilization, that is, the union of the sexual cells, are best studied in some of the lower invertebrates such as Ascaris or Echinoderms."[2]

Although the physician has been looked upon as a primary source of sexual knowledge, his preparation for this role has been far from adequate. The 1961 study by Greenbank[3] is an example. He surveyed five medical schools in the Philadelphia area and showed that 50 per cent of the medical students at that time believed that masturbation caused mental illness. If this was not bad enough, he further pointed out that 20 per cent of their faculties shared in this impression. Dr. Frank Lock (then the President of the American College of Obstetricians and Gynecologists) addressed the Fellowship in 1964 on "The Challenge of Change." He reported that only one medical school in the entire United States had a well coordinated program of instruction in the sexual adjustment of marriage and marriage counseling. He pointed out that surveys done by the college had indicated that only one in eight general practitioners felt he was adequately prepared by his training to offer sex education and marriage counseling, although most of them felt this was an essential part of their practice. Ninety-five percent of the Fellows of the college found that they needed to do counseling as part of their practice but only 15 per cent of them felt that they had adequate training with which to accomplish this

* Presented before the Section on Psychiatry and Neurology, 204 Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1970.

work. Fortunately, such leadership has led to a gradual change in the attitudes of medical schools so that many new training programs are being devised.

The changing roles of man and woman in our society in the past century have created a greater need for sexual knowledge in order to produce happier individual lives and better marriages. The marriage of the pre-industrial revolution period probably required far less contraceptive knowledge as large families were an asset to an agrarian society. Extra boys meant a better work force on the farm. The marriage did not require any great effort on the part of the husband to produce sexual satisfaction in his wife. The husband found sexual favors to be his right in marriage and his wife was a submissive partner. Childhood sexual curiosity was successfully managed by suppression. A child in the pre-teen years managed to show no external evidence of his sexual interest under such parental attitudes, thus leading to the concept of latency. With the changing social patterns produced by the industrial revolution and the break-up of the patriarchal farm, sex roles have changed. Women were no longer totally dependent on their husbands or fathers for support and were able to obtain employment in factories and establish an independent existence. The feminist movement of the late 1800's and early 1900's contributed to the changing role of women, and today we deal with the modern nuclear family where man and woman meet as equals in marriage.

What preparation do they have to deal appropriately with the sexual aspects of marriage? In mammals, below the level of primates, instinctual behavior has been studied experimentally. If male rodents are reared in total isolation from females, they will copulate effectively with an estrous female at the first opportunity. As we ascend the scale to the primates, we find that sexual behavior is much conditioned by learning. Early socialization patterns in the chimpanzee involve sexual games including attempts to affect coitus. These lead gradually to a point of physical maturity when the animals are capable of effective mating. When this training has not occurred prior to maturity, sexual arousal can take place in the male but he seems unable to copulate with a fully receptive female. It seems evident that sexual behavior in humans is clearly conditioned by childhood training. Comparative studies of a number of primitive societies reported by Ford and Beach[4] have shown a wide range of acceptable sexual behavior in children. In the restrictive societies, any pre-adolescent sexual outlet is severely punished even to the point of death in some. In very permissive societies, adults take a tolerant view of sexual expression in childhood. Under such circumstances infants are observed to progress from genital handling in infancy to sex play with other children as they become old enough to walk about. In several Polynesian societies, children masturbate freely and openly in public. They play sexual games and simulate intercourse. These societies allow children freedom to observe adult intercourse and to participate in discussion of sexual matters. Individuals under these circumstances gradually increase their sexual outlets as they approach puberty and adolescence. By the time of puberty sexual expression consists predominately of the adult form of heterosexual intercourse. In one African society parents believe that unless children exercise themselves sexually early in life they will never beget children. The Lipcha of India believe that girls will not mature without benefit of sexual intercourse. Without repressive action by the adult members of the society, there is a gradual and uninhibited development of sexuality from infancy onward. There is no evidence whatsoever of the latency period which is seen in the restrictive societies.

Let us compare these zoological and anthropological evidences of sexual behavior with that of our own society. Ours is a restrictive society in which we do not formally accept any sexual outlet in the young, or old, other than intercourse in the married adult. These values are deeply rooted in our religious thinking and enforced by our laws. To adhere to these values it has often been necessary to establish a pattern of training which makes

adult sexual adjustments difficult. Children face criticism and punishment whenever they engage in genital handling. Excretory functions are considered dirty and are dealt with in a negative way. Since the genital organs are identified with the excretory function, they are negatively labeled. In many cases they are nonlabeled so that there is no acceptable language with which to deal with these organs. Thus, the penis and vulva are either "it," "down there," or one of a number of less pleasant sounding entities.

In the effort to teach modesty, there is often emphasis on the shamefulness of the body. This is usually the result of over-reaction of the parents to the child's exposure of his body or the reaction to the child encountering the parent in the nude. Adult attitudes toward masturbation are conditioned by Judeo-Christian thinking which held that intentional wastage of seed was a violation of divine command to be fruitful and multiply. Thus, any masturbatory behavior is, generally, guilt-ridden. This guilt was further emphasized by the early Christian thinking that sexual desire was the result of original sin and its fulfillment was acceptable only in procreation. It was taught that masturbation led to mental illness, death, and damnation. Our original antipornography legislation (such as the "Comstock Laws") was principally aimed at preventing the dissemination of literature that would lead young men to masturbate. These are some of the negative attitudes produced by parents in the rearing of children.

In the current argument about sex education in schools, it is often held that formal sex education should be provided by the parents. Today this is done in a limited way but it is restricted by several factors. One is the limited knowledge and ability to teach on the part of the parents because of the inadequacy of their own training. Parental inadequacy in such matters may also be due to the fact that such discussions suggest the sexual nature of the parents. Furthermore, it may be viewed by some as being seductive and in violation of incest taboos.

In the absence of adequate parental sources of information, children resort to their peers and mass media. Males learn that sexual knowledge is equated with masculinity. Thus, they are threatened by any effort to inform them as their image of themselves demands that they "know it all."

With this background of negative conditioning, suppressed sexual outlets before marriage, and lack of sources of sound sexual information, it is surprising that adults in our society function even reasonably well as sexual partners. In a number of cases, inadequate information and misinformation on such simple matters as reproductive anatomy and physiology lead to great hardship. Incredible stories have been reported such as those of couples who slept together and did not know why they could not conceive until it was pointed out that intercourse was necessary. Cases have been described where couples have been married for a number of years before consulting a physician about their inability to consummate a marriage because of mechanical obstruction. More common anatomic concerns include fears about over-or undersized genitalia. Would a tall man have a penis too large for his small wife? Will a short man be able to satisfy his wife? Dr. Masters'[5] findings in regard to relative uniformity of the size of the erect penis and the uselessness of greater penile size should be reassuring to patients with such concerns. The great distensibility of the vagina in compensating for what minor differences of size may exist can be pointed out. Couples may have disagreement as to what coital technics are acceptable. Childhood conditioning may lead them to look upon various types of oral or manual stimulation as perversion. Kinsey's[6] description of oral-genital practices as good mammalian behavior seems appropriate. Much unhappiness can be traced to the mistake made by both men and women who use themselves as a yardstick in measuring their partners. Unfortunately, it is not sufficiently obvious to these individuals that a female cannot display male sexual behavior or vice versa. A man who is sexually stimulated by his wife's nudity does

not understand that his own bare body does not excite his wife. Such a man is likely to approach his wife sexually with direct genital stimulation as he would like to be approached. He has had no way to find out that women in contrast to men generally prefer emotional stimulation in the form of tender exchanges of love talk before any specific sexual contact. Kinsey[6], in pointing out why some women prefer homosexual relations, suggested that women are more likely to understand the anatomy, psychology, and responses of their own sex. Since there has been no way to teach one sex about the other, couples must be encouraged to share their knowledge of themselves with their partner. An excellent example of such a situation is described by Churnick and Churnick[7]: "A junior intern and his wife were treated for sexual dysfunction involving the wife's lack of orgasm. He had had successful intercourse with another girl before he met his wife. He had found his wife passionately aroused during premarital petting so their sexual dysfunction after marriage came as a considerable surprise. He consulted a marriage manual for information about effectively stimulating women and followed the recommended technics to the letter, including vigorous massage of the head of the clitoris. He was amazed to hear from his wife that this rubbing was painful and did as much as anything to turn her off. As part of the treatment in this case the physician explained our cultural stereotype that men know all about sex, giving the intern permission to admit his ignorance. This reduced the husband's anxiety. The physician then encouraged the wife to educate her husband concerning the kinds of stimulation she did enjoy and in what sequence. At their next visit the very pleased young intern reported that his wife could give him more useful information about her sexual response than could the various marriage manuals which he had consulted."

There is still a great deal of unhappiness in marriage due to fear of pregnancy and faulty contraceptive methods. Coitus interruptus is widely practiced despite the high pregnancy rate and the tensions produced. Fortunately, the acceptability of medical advice in the contraceptive field has become quite common and ignorance of effective contraceptive measures is less of a problem than it had been in the past.

The shift in emphasis in the sexual role of women from the passive to the active partner has probably created as much mischief in the marriage relationship as any change in recent times. At the turn of the century a good wife was better prepared by her childhood conditioning since it was enough that she merely submit to her husband's marital embrace. If her husband did not bring her to orgasm, he certainly would not look upon himself as a sexual failure. Today, the change from childhood female sexuality to that of the adult is far more drastic. Until the time of her marriage, the young girl is expected to be almost completely asexual. As she progresses through the dating game, she is expected to be attractive enough to keep her telephone ringing, but she must know how to say "no" at the appropriate moment. Margaret Mead[8] describes this quite well when she says, "To respond positively includes the ability to say 'no,' to postpone, delay, and to repulse without offending during the long years of dating. The whole pattern places heavy demands upon both men and women, not the least of which lies in the contrasting role of play without completion appropriate to dating, and the shift to complete sex satisfaction in marriage." The sexually successful woman is expected to be a completely responsive tigress regularly achieving complete orgasm, or, better, multiple orgasms in spite of the inhibitions her developing emotional system was exposed to. Not only is she expected to achieve orgasm, she is expected to achieve it in the vagina and if she receives her orgasm in the clitoris she is viewed as immature. Again, we appreciate the findings of Masters and Johnson[5] in disspelling this misinformation. Since much of the writing about appropriate female sexual response has come from males, it is refreshing to go back again to the writing of Margaret Mead[8], who in 1953 pointed out, "Experiencing a positive sex climax is probably no more congenial to the

whole female sex than was the passive unemotional role demanded of their great-grandmothers. These demands forced some women to learn to simulate as they have always had to learn to simulate through the ages in order to conform to the current style in sex behavior."

We have tried to review some of the backgrounds of out thinking of the development of sexual behavior in our society, the limited resource that individuals have in instinctive behavior, and the kind of training they are likely to be exposed to. Formal sex education in the schools does not seem to provide an answer since that which would be acceptable at the present time does not seem to go beyond the basics of human plumbing. It therefore seems inevitable that for some time to come physicians and others in the health profession will be called upon to correct the damaging effects of sexual ignorance. It is to be hoped that improvements in the training of such professionals will better equip them to perform their task.

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Hunterdon Medical Center

"Driver Limitation" Exhibit

To provide practicing physicians with information on the role of physical and mental considerations in traffic safety, the AMA has created a new exhibit, "Medical Aspects of Driver Limitation." This is a ten-foot illuminated exhibit which illustrates that driver impairments are involved in more than 50 per cent of all auto crashes, and in an even higher proportion in crashes involving fatalities. It also lists the measures physicians can take to reduce this toll, features publications and guides for identifying and correcting drivers' limitations, and visually projects slides of 20 common impairments.

The exhibit is designed for national medical meetings, but arrangements may be made for presentation at state and specialty society meetings by writing the Committee on Medical Aspects of Driver Limitation, AMA, 535 North Dearborn Street, Chicago 60610.

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The original *Manual on Chemical Tests for Intoxication*, which discusses the value, interpretation, and medicolegal aspects of chemical tests in relation to traffic law enforcement (driving while intoxicated), as well as the pharmocologic action of alcohol, is now available to you at a reduced price. The basic information in the manual is applicable and accurate in 1970. This book is available at 75 cents. Interns, residents and medical students may have it for 40 cents. Order it from the AMA as OP-193.

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Here is a routine for inevitable abortion which seems to permit earlier control of sepsis and minimizes the risks.

Aggressive Management Of Incomplete Or Inevitable Abortion*

Report of 1002 Septic and Aseptic Patients

James L. Breen, M.D.; Caterina A. Gregori, M.D./Livingston; and William Connolly, M.D./Newark

With its complications and sequelae, abortion occurs in up to 20 per cent of all pregnancies and is widely recognized as a major cause of maternal death. This municipal hospital,† in particular, with its limitations in physical, professional, and financial resources, has responded by a search for ways to alter management of these patients so as to provide the maximum in safety, comfort, and rehabilitation of the patient without excessively taxing hospital facilities.

The problem no longer is whether all abortas may be curetted immediately, regardless of the presence of sepsis. Our findings[1] have proved that immediate curettage is preferable to the earlier methods. The questions now are: Can the curettage be performed outside the operating room, and under intravenous sedation-analgesia, with satisfactory relief of pain? What are the complications of this routine? How quickly can these patients be treated, then returned to their families?

In January, 1959 we adopted the aggressive approach to treatment of incomplete abortion. The patients on our service came almost entirely from the economically deprived segments of an urban population. They had little or no financial resources, and usually were malnourished and anemic. In many cases the abortion already had occurred and had been neglected until symptoms became alarming. To reduce the load on the in-patient facilities we began to perform curettage immediately in the emergency ward, on an out-patient basis, after the required initial preparation. To carry out the procedure without causing undue discomfort (yet eliminate the hazards of anesthesia and the disadvantages involved in use of the operating room and staff) we administered sedation-analgesia by vein. The technic and the experience we thus acquired, in septic and aseptic patients, have been described.[1]

Investigational Material

This segment of the investigation began in January, 1966 and continued for 33 months. The series comprised 1002 abortas. *Table 1* gives a statistical profile of these patients. The patients were regarded as septic if, on entrance to the emergency ward, (a) the temperature was 100.4 or higher and was unattributable to other cause; (b) interference with the preg-

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†The Martland Hospital Unit in Newark, New Jersey.

Table 1

Patients Admitted for Out-Patient Treatment of Incomplete or Inevitable Abortion

		No. Patients	Per Cent
Age range, years	12 to 48		
Average	24		
Septic		276	28
History of chronic infections or disease:			
Gonorrhea		36	
Diabetes		22	
Tuberculosis		10	
Blood dyscrasias		8	
Syphilis		7	
		83	8
Pregnancies:			
Range	2 to 15		
Average	5 per patient		
Multigravidas		790	79
Grand multigravidas (5 pregnancies or more)		297	38
Parity:			
Range	0 to 13		
Average	3 per patient		
Abortions:			
Range	1 to 6		
Average	2 per patient		
Size of uterus, weeks:			
Range	4 to 20		
Average	12		
Hemoglobin, less than 10 Grams:			
Aseptic		97	13
Septic		64	23

nancy by the patient or others was admitted or suspected; (c) malodorous lochia was present and (d) the parametrium and adnexa were tender. Of this series, 28 per cent were diagnosed as septic.

Treatment

Our method is to take the patient immediately to the treatment room of the gynecology service, where examinations and diagnostic studies are performed, as follows:

1. A speculum examination to determine the status of the cervix and to obtain specimens from the endocervix for culture and Gram staining.

2. A pelvic examination to determine the patency of the cervical os, and the size, position, consistency, and tenderness of the uterus.

3. (a) A complete blood count, reticulocyte count and sedimentation rate. (b) Complete urinalysis. (c) Determinations of blood sodium, potassium, chloride, urea nitrogen, carbon dioxide, and creatinine. (d) Bilirubin, total and indirect. (e) Blood type, Rh compatibility and VDRL. Blood is cross-matched for 2 units. (f) Prothrombin time and fibrinogen. (g) Blood cultures, aerobic, and anaerobic. (h) Chest roentgenogram and flat plate of the abdomen, if indicated.

If the cervix is dilated, routine medical treatment is administered: (a) Intravenous fluids. (b) Synthetic oxytocin, 40 units per liter, intravenously. (c) If the patient is septic, antibiotics, preferably Ampicillin, initial dose of one Gram intravenously, then 2 Grams every 8 hours; or sodium cephalothin, initial dose of one Gram intravenously, then 0.5 Gram intravenously every 6 hours.

If toxic shock is impending (chills, hypotension, nausea, vomiting, diarrhea, tachypnea, oliguria—urinary output of less than 500 cc. per 24 hours), (a) Central venous pressure is determined; (b) The patient is catherized and the hourly urinary output is recorded; (c) Antibiotics are administered intravenously —aqueous penicillin G, 30 million units per day; Kanamycin, 750 mg. every 12 hours; Colistin, 2.5 to 4.5 mg. per kilogram per 24 hours; in the presence of penicillin allergy, sodium cephalothin is substituted, in doses of one Gram initially, then one Gram every 6 hours.

If *toxic shock is present*, with hypotension (systolic pressure of less than 80 mm.), (a) whole blood or fluids are administered intravenously to raise the central venous pressure to 12 to 15 cm. of water; (b) if kidney perfusion is inadequate, as indicated by urinary output of less than 30 cc. per hour, step "a" is repeated; if, after the central venous pressure has been raised to 12 to 15 cm. of water, the urinary output is still insufficient, Isoproterenol solution, 2.5 mg. per 1000 cc., is administered at approximately 0.5 to 1 cc. per minute—this is titrated against the volume of a satisfactory urinary flow; if Isoproterenol

does not establish an adequate urinary output, one ampule of Mannitol may be tried; (c) in the presence of renal failure (anuria) strict control of electrolytes is required with limitation of fluid intake to 0.2 cc. per kilogram of body weight per 24 hours, plus a quantity equal to the amount of urine excreted in the previous 24 hours.

The time from out-patient admission to curettage for the septic patients with incomplete abortion averaged the same as for the aseptic group—about one hour. An occasional patient was admitted and treated for threatened abortion, and was followed until evacuation of the uterus was required. This, therefore, necessitated a delay.

Preoperative Medication. At the beginning of the pelvic examination before curettage, each patient received an intravenous injection of propiomazine[3] and meperidine for sedation-analgesia, except in the presence of hypotension, in which case no or less than the usual dose of meperidine was administered. The dose generally used consisted of 40 mg. propiomazine and 50 mg. meperidine. Variations in a few cases were necessitated by low blood pressure levels on admission. Dosage was about the same in the septic and aseptic groups.

After adequate antiseptic preparations of the vagina, a tenaculum was placed on the cervix, and the uterus was evacuated first by a sponge stick, then by a sharp curette.

Results

In most patients the emotions and sensibility to pain were well controlled during the operation. None reacted as unpremedicated patients would have done; i.e., by moving on the table and resisting the procedure. The clinicians evaluated the sedation-analgesia as satisfactory in 94 per cent. (Table 2).

One of the most significant and predictable results was the decrease in blood loss. The average loss was 103 cc.; only three patients lost 500 to 1000 cc. (Table 2). The transfusion rate was 7 per cent—a remarkable figure in view of the fact that, on admission, 16 per cent of the patients had hemoglobin values of less than 10 Grams (Table 1).

Table 2

Results of Preoperative Medication and Curettage

	No. Patients		Per Cent
Sedation-Analgesia, All Patients			
Clinicians' over-all evaluation, satisfactory (excellent-good)			94
unsatisfactory (poor)			6
Clinicians' evaluation, patients with painful adnexa satisfactory			90
nonpainful adnexa, satisfactory			95
Patients' judgment, those with painful adnexa, satisfactory (fair to excellent)			64
nonpainful adnexa, satisfactory (fair to excellent)			80
Bleeding during Curettage All Patients			
Severe	41		4
Moderate	466		47
Mild	495		49
After Curettage			
Severe (septic, died)	1		0.1
Moderate	53		4
Mild	948		95
Estimated Blood Loss during Curettage, cc.			
25-50	42		4
50-100	791		79
100-200	(129)		
200-500	(37)		17
500-1000	(3)		
Range—25-1000		1002	
Average 103			
Transfusion Post Curettage, cc.			
Aseptic patients			
Range 500-6000	42		6
Average 67			
Septic patients			
Range 500-2000	29		11
Average 1052			

Postcurettage complications

The initial curettage controlled bleeding in almost all cases. Only 4 patients (3 aseptic) or 0.4 per cent, required one repeat operation. Ninety-eight patients were considered anemic post curettage, an over-all incidence of 10 per cent. After the procedure, 13 patients (one per cent of the total series) temporarily went into shock, which was promptly reversed by standard measures. In no patient, even those in whom sepsis had appeared most severe, did endotoxic shock develop or was there evidence of spread of the infection. Earlier reports state that such complication may be expected

[3]We used the Wyeth brand tradenamed Largon®

in 2 to 4 per cent,[1] and may occur in up to 20 per cent.[2] The uterus was not perforated in any case, nor was hysterectomy or ligation of the vena cava necessary.

Of the 726 aseptic patients, 82 per cent (those admitted for treatment of uncomplicated, incomplete abortion) were discharged in an average of forty-three hours. The remaining 18 per cent were detained an average of eighty hours because of: (a) delay in performing curettage when, on admission, abortion had threatened or had been imminent, or (b) for post-operative treatment of underlying disease or persistent infection, or (c) to obtain blood of required type, laboratory reports, or surgical or other consultation (as for roentgen study after evacuation of a molar pregnancy). (Table 3.)

Of the 276 septic patients, nearly 70 per cent (those with no problem other than sepsis) were discharged in an average of forty-seven hours. Thirty-eight per cent were detained an average of eighty-four hours for special reasons, as described for the aseptic group. There was one death in eight hours (less than 0.1 per cent). (Table 3.)

Table 3

Final Outcome of Curettage under Intravenous Sedation-Analgesia

	No. Patients	Per Cent
Uneventful recovery, all patients	986	98
Total Hospital Stay, hrs.		
Aseptic		
Uncomplicated, incomplete abortion range, 14 to 68 *average*, 43	595	82
Complicated cases, including patients admitted in threatened or inevitable abortion range, 70 to 206 *average*, 80	131	18
Septic		
Cases with no complication other then sepsis range, 20 to 68 *average*, 47	170	61.9
More complicated septic cases range, 70 to 206 *average*, 84	105	38.0
Death in 8 hrs.	1	0.1
Over-all average total hospitalization, hrs.		
Aseptic *average*, 51	726	
Septic *average*, 61	276	

When the over-all hospitalization was calculated for the septic patients, the total stay for the group averaged only sixty-one hours. When the hospital stay for all 726 aseptic patients was computed, the total hospitalization averaged only fifty-one hours. The 10 hour difference is of no clinical significance.

Mortality

The one death in this series of 1002 patients represented a mortality of less than 0.1 per cent. The patient, an 18 year old woman (gravida 6, para 5, aborta 1), was admitted to the treatment room at 1 p.m. with a history of four days' vaginal bleeding. She was hemorrhaging heavily, had a temperature of 101, blood pressure of 110/70, and pulse rate of 118. The uterus was firm and the size of a 12 weeks' pregnancy, with cervix 2 cm. dilated, and products of conception at the cervical os; the adnexa were not tender. The findings in hemoglobin and hematocrit determinations (8 Grams and 24 per cent respectively) confirmed the initial clinical impression of anemia. She received intravenous infusion of oxytocin; aqueous penicillin G, 10 million units; and chloramphenicol, 2 Grams per 1000 cc. of fluid, with 50 mg. meperidine and 40 mg. propiomazine, and was curetted in 30 minutes after admission. Blood loss at operation was estimated at 1000 cc. Hemoglobin was 7.2 Grams and hematocrit 21 per cent post curettage. Her temperature remained at 101. Four hours later, as blood was being sought, vaginal bleeding recurred. She was curetted again but no tissue was obtained. The clotting time, which initially had been normal, now was considerably prolonged and clot formation poor. Despite transfusion of 2000 cc. whole blood and administration of alpha-aminocaproic acid and fibrinogen, hemorrhage persisted. The patient died one-half hour after recurrence of bleeding (6 p.m.). At autopsy, the uterus was intact and endometrium smooth; there was no sign of extraperitoneal spread of the infection. Death was ascribed to shock secondary to prolonged, untreated hemorrhage, complicated by the infection in the uterus and a coagulation deficiency.

Discussion

This series of 1002 patients represents a sizable number in need of hospital care on an emergency basis. If an admission procedure were developed in which such patients were (a) examined immediately, (b) speedily diagnosed as to presence or absence of sepsis, and (c) curetted, if indicated, as promptly as possible, a relatively short hospital stay could be expected. Such aggressive management, by rapidly removing the nidus of infection, would enable the antibiotic medication and the natural defenses of the body more quickly to overcome the residue.

Immediate or early evacuation of bleeding tissue provides hemostasis, which is essential to such malnourished, anemic patients. Because the need of transfusion is reduced, the difficulties frequently involved in obtaining adequate amounts of the required blood types and the risk of hepatitis are minimized.

The aggressive method also eliminates (a) the need of operating room space and personnel, which may not be immediately available in a large city hospital, as well as (b) the hazards of general anesthesia and (c) the necessity for the services of the anesthesia staff. (d) The period of in-patient care is shortened, enabling earlier release of beds for other patients.

Summary

In 1002 consecutive cases of abortion, sepsis was present in 28 per cent. Curettage was performed, usually within an hour, under intravenous sedation-analgesia regardless of infection. Pain was satisfactorily controlled in 94 per cent. No endotoxic shock developed—a most important finding. No hysterectomy or ligation of the vena cava was required.

There was no clinically significant difference in the total hospitalization for both groups, which averaged two days, three hours for the aseptic, and two days, thirteen hours for the septic patients.

The one death (mortality, less than 0.1 per cent) was ascribed to shock secondary to prolonged, untreated hemorrhage, complicated by the uterine infection and a coagulation deficiency.

Aggressive management of septic abortion, with immediate curettage (1) permits earlier control of sepsis and its sequelae; (2) favors reduction in blood loss, thus minimizes the risks associated with anemia and transfusion; (3) shortens the period of in-patient care in comparison with the time required for recovery when operation is delayed and enables earlier release of beds for other patients; (4) use of intravenous sedation-analgesia for the procedure eliminates (a) the disadvantages of general anesthesia, (b) the necessity for anesthesia personnel, and (c) the need of operating room space.

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(This editorial appeared in the October 1967 JOURNAL)



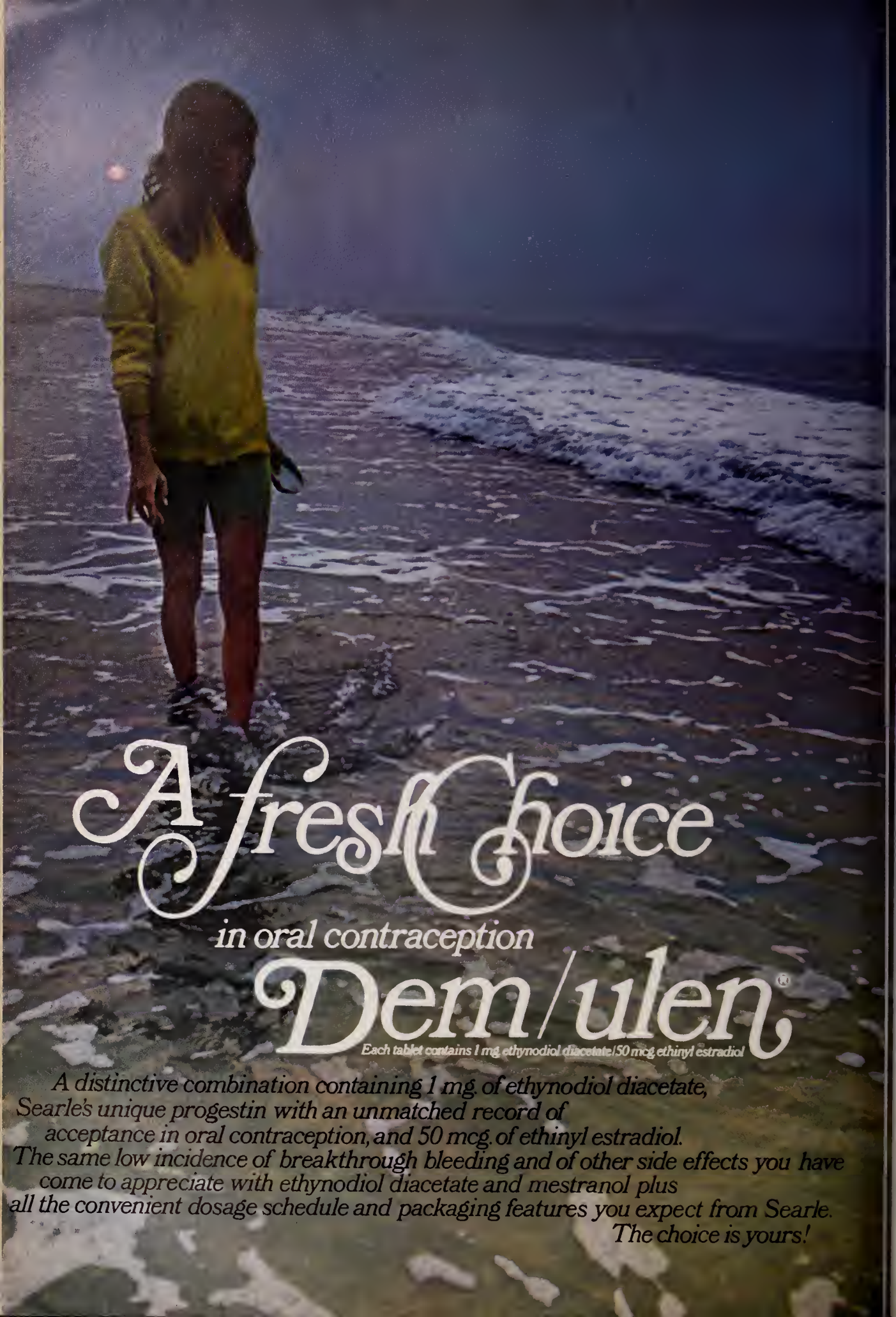
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Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision. Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.



Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

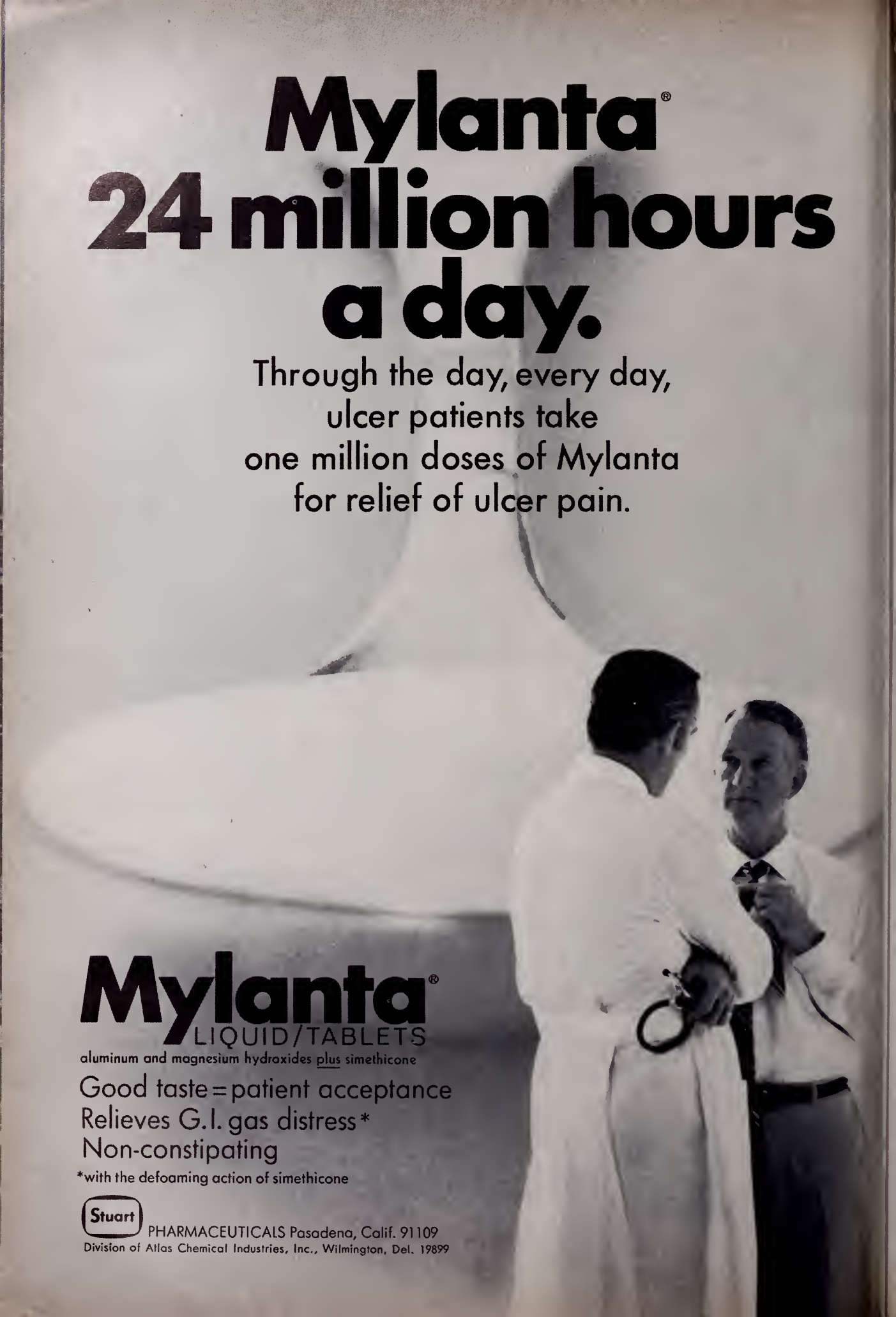
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Muscle diseases are, perhaps, the least studied of all human ailments. Here is a consideration of polymyalgia and polymositis.

Muscle Disease — Current Concepts*

Lonnie B. Hanauer, M.D./Millburn

Along with other organ systems in the last twenty years, there has been great progress in the understanding of the anatomy, physiology, and biochemistry of muscle. In turn, knowledge of the pathophysiology of muscle has increased, new diseases have been described and sophisticated diagnostic technics have become available at the community hospital. Advances in therapy have also occurred but they are frequently less dramatic.

Table I outlines present methods for evaluation of muscle disease. Clinically, it is a useful generalization that distal weakness is neuropathic while proximal weakness suggests muscle dysfunction. The patient with a myopathy cannot climb stairs or raise his arms but his grip may be reasonably good. Muscle tenderness on examination suggests myositis.

TABLE I

Muscle Disease Diagnosis

I. Examination
  A. Weakness: Proximal-muscle
     Distal-nerve.
  B. Pain, tenderness, wasting.
II. Laboratory
  Enzymes-muscle damage: CPK, Aldolase, SGOT.
III. Electromyography (EMG)
IV. Biopsy: carefully selected site.
     special stains.

Measurement of serum enzymes useful in evaluating muscle damage began with the transaminases during the 1950's. Currently however, creatine phosphokinase (CPK) can be measured in most hospitals and is most useful since it exists in the body almost exclusively in striated muscle.[1] Elevation therefore indicates damage to skeletal or cardiac muscle. Most commonly used to diagnose myocardial infarction, this enzyme is also elevated in myositis, dystrophies, myoglobinuria, and crush injuries. Slight elevation may occur with surgery, other myopathies, and myasthenia gravis. Levels are normal in polymyalgia and in CNS or peripheral nerve disease.

Electromyography and nerve conduction studies are less widely available. EMG examination is tedious. Testing and interpretation are generally performed by physicians specializing in physical medicine. The EMG is useful in differentiating disease of the anterior horn cell, peripheral nerve, and neuromuscular junction.[2] Myopathies, dystrophies, and myasthenia can also be differentiated. Muscle biopsy may prove to be disappointing. Selection of proper biopsy site may be the most difficult part of the procedure. The muscle selected should be actively involved with disease: that is neither free of disease nor burnt out fibrotic tissue. Besides routine stains, pathologists interested in muscle will use histochemical and biochemical technics along with electron microscopy.[3] A recent review cited fourteen muscle biopsies, twelve of which were normal on "routine" staining where nine diagnoses of myopathies could be made with special staining methods. Most of these were in the non-progressive myopathy group described below.

Table II shows a rough distribution of patients followed in a muscle disease clinic. Patients with myasthenia gravis are seen elsewhere. Muscular dystrophies compose the largest group and these will not be discussed.

* Presented in part before the Section on Rheumatism, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1970. Dr. Hanauer is clinical assistant professor of medicine, New Jersey College of Medicine and Dentistry, Newark, New Jersey.

Myositis (with or without skin involvement) is relatively common. This condition frequently responds well to treatment and a case will be presented below. Neurogenic atrophies (such as amyotrophic lateral sclerosis) are not really primary muscle disease.

TABLE II

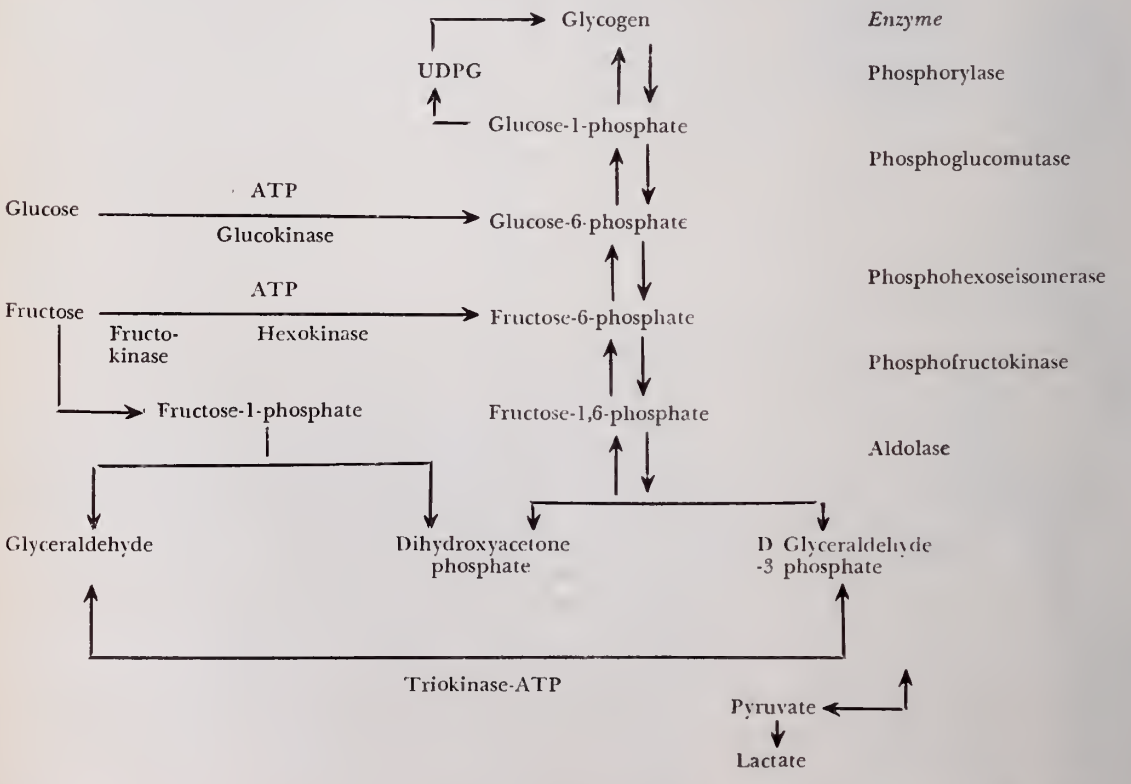
Distribution of Muscle Diseases

I. Dystrophies (55%)
   Duchenne—40%
   Myotonic dystrophy and myotonias—5%
   Other dystrophies—10%
II. Polymyositis and dermatomyositis—adult and children—(20%)
III. Neurogenic muscular atrophies—(15%)
IV. Non-progressive myopathies—(5%)
V. Miscellaneous—(5%)

The non-progressive myopathies are rare but their pathologic and biochemical characterizations are of great interest. Minor biochemical "myopathies" may be found in the future to account for a number of chronic musculoskeletal complaints. McArdle's Disease[4] or muscle phosphorylase deficiency was first described in 1951.[5] As of 1968, thirty-two papers about this condition have been written by sixty-four authors, but there have been only thirty-one patients with the disease. McArdle's original patient was not terribly ill but complained of weakness and cramping after moderate degrees of exercise. Instead of dismissing these complaints, McArdle studied the patient and noted that venous lactate concentration failed to rise after exercise. Further investigation and special staining of muscle biopsies revealed the absence of phosphorylase so that glycogen could not be converted to glucose-l-phosphate and on to lactate. Myoglobinuria with dark urine may occur and elevations in serum enzymes such as CPK indicate muscle damage. The defect is generally non-progressive, inherited as an autosomal recessive gene and may respond clinically to ingestion of large amounts of fructose which enters the glycolytic cycle beyond the stage requiring phosphorylase.

Since McArdle described this condition other myopathies have been associated with deficiencies in most of the enzymes involved in glycolysis (Figure 1). These include phos-

Figure 1. The Embden-Myerhof Glycolytic Pathway



phofructokinase, phosphoglucomutase, phosphohexoseisomerase, and the glycogen storage diseases. Recently, Engle[6] described twin girls with muscle cramping and myoglobinuria associated with a defect in lipid, rather than carbohydrate metabolism.

Other non-progressive myopathies first described in the last ten years[1] are associated with congenital defects in muscle cell structure.[3] Nemaline or rod myopathy presents as generalized muscular weakness in early childhood. More severely affected children with this autosomal dominant disorder may be unable to walk. Specially stained muscle biopsies reveal abnormal rod-shaped structures within the muscle fiber which appear to be excessive Z-band material. One or more of the contractile proteins of muscle appear to be over-produced or abnormally stored. Morphologic defects in the mitochondria have been noted on electron microscopy in another myopathy of children and young adults. Other defects noted have been central cores or holes in muscle fibers and the persistence of a fetal muscle pattern with central nuclei called myotubular myopathy. It seems relatively certain that more structural and functional muscle abnormalities will be described in the near future.

Polymyositis and polymyalgia rheumatica differ from most of the conditions mentioned above in that they are more commonly seen, tend to have a finite duration and may respond quite well to treatment.

A 26 year old woman was well until August 1968 when she noted an ear infection, dizzy spells, feelings of fatigue, and pain and tenderness most apparent in her thigh muscles. Shortly thereafter her ankles became swollen and red and she developed a fever. In October she was admitted to the Rahway Hospital. After a muscle biopsy she was told she had "allergic vasculitis." Before discharge she was started on prednisone 60 milligrams a day. This was tapered rapidly to 15 milligrams. In late November her symptoms increased and she was rehospitalized and told that she had polymyositis. In December she had difficulty in swallowing and was regurgitating liquids. Prednisone was increased to 45 milligrams and she began to improve. In March 1969 with her prednisone dose at 15 milligrams daily she developed an upper respiratory infection and again noted an increase in her muscle symptoms. She was rehospitalized in early May. Weakness was marked and her prednisone was increased to 160 milligrams a day. She was first referred to my office in June 1969. She said she was getting weaker and also complained of difficulty in swallowing.

Examination of the head, chest, heart, lungs, and abdomen was unremarkable. Major physical finding was severe proximal muscular weakness. She was unable to lift her arms and legs against the force of gravity. Grip strength was only slightly diminished. Muscle tenderness was present in the shoulders and thighs. Joints were normal. Hemoglobin was 13.5, WBC 14700, sedimentation rate 6, and test for rheumatoid factor was negative. SGOT was 30, CPK was 8.3 (within normal range). It was felt that 120 milligrams of prednisone was excessive and she was tapered over the next three weeks down to 60 milligrams. On June 24, CPK rose to 17 and SGOT to 53. In the hope of avoiding the side effects associated with continuous high doses of steroids, azathioprine (Imuran®) 100 milligrams was added to her drug regimen. Her SGOT and CPK returned to normal levels and in mid July tapering of her prednisone was resumed.

Since that time her muscle enzymes have remained normal except for a few brief minor elevations of her CPK. Her prednisone was tapered slowly throughout the winter reaching a dose of 15 milligrams once daily. Azathioprine was continued at 100 milligrams per day until May, 1970, but is now being tapered. White cell and platelet counts have never been affected by Imuran® therapy and in April her SGOT was 28, CPK 8.4, and sedimentation rate 4. Muscle strength has improved to the point where she can perform all necessary functions. She climbs stairs and gets out of a chair with ease, something she could not do when first seen; and there is no longer any muscle tenderness.

This represents a typical case of moderately severe polymyositis. Muscle biopsy from a site of actively involved muscle shows inflammatory infiltration of the muscle fibers with areas of edema, degeneration, and necrosis. Areas of inflammation often surround small blood vessels but do not involve them. With skin involvement, the condition is called dermatomyositis rather than polymyositis but the course and treatment of the desease are no different with skin lesions.

Onset may be at any age. Childhood dermatomyositis resembles the adult condition and in some studies[7] the incidence is relatively high in the first decade. Weight loss and fever are common. Muscles, especially those of the shoulder and pelvic girdles are weak and atrophic and involved areas are tender. Climbing steps, rising from a chair, and combing hair are among the first difficulties encountered. The head may fall forward with neck involvement and dysphagia may occur with involvement of the striated muscles of the upper esophagus.

Serum enzymes, especially CPK, aldolase,

and SGOT are elevated and creatinuria occurs. Biopsy, if positive, confirms the diagnosis and the EMG is also helpful.[8] Primary treatment is with steroids, generally beginning with about 60 milligrams of prednisone daily. Fall in enzyme levels should occur in a few weeks and precedes clinical improvement. Death may occur but recovery is the rule in patients without underlying malignancy. Malignancy as an underlying cause of myositis is relatively common in older patients.[9] Steroids may eventually be discontinued in some patients but long-term suppressive therapy is often needed. The patient presented showed signs of low grade inflammatory activity after many months of therapy and immunosuppressive drugs were added in the hope of allowing a lower steroid dose. This has been the case, coincidental though it may be.

An 80 year old man was seen at the arthritis diagnostic clinic at the Children's Specialized Hospital in Westfield on September 9, 1969. Following a period of stress (when his wife underwent surgery a year earlier) he complained of feeling "nervous" and developed pain in both thighs. The thigh pain and stiffness were most severe upon arising in the morning but began to improve after he was on his feet and walking for thirty to sixty minutes. Symptoms gradually became more severe and appeared in the shoulders. He noted no fever, systemic symptoms, or visual problems but the discomfort at night interfered with his sleep. There were no symptoms localized to the joints. He received aspirin, indomethacin and phenylbutazone all without relief. He had undergone a left lumbar sympathectomy seven years ago for poor circulation in the left leg, and had a history of a hiatus hernia. General physical examination was unremarkable except for a grade II systolic murmur along the left sternal border. He showed pain with slight shoulder rotation and an inability to lift his arms much above the horizontal because of pain. There was no muscle tenderness. Elbows, wrists, spine, and hands were normal. There was pain with hip flexion or rotation but no muscle tenderness in the thighs. Knees, ankles, and feet were normal. Pedal pulses were diminished but were equal bilaterally. Sedimentation rate was 27 and test for rheumatoid factor was negative.

The patient's story of cramping, stiffness, and pain in the area of the shoulders and thighs most marked before and shortly after arising in the morning with no apparent joint abnormalities seemed to fit the description of *polymyalgia rheumatica*. The sedimentation rate which was barely elevated, however, did not fit the usual description for this condition. He was started on a program of physio-therapy, muscle relaxing drugs, and aspirin. Symptoms became more incapacitating so that in October he was admitted to Overlook Hospital, Summit. Two sedimentation rates were 18 and 25. CPK and SGOT were normal. Serum iron was 32, iron binding capacity was 400. Three stools were positive for occult blood. X-ray showed a hiatus hernia without evidence of ulceration. Sigmoidoscopy and intestinal x-rays revealed no source of bleeding. The gastroenterological consultant felt that, in view of his age, repair of the hiatus hernia was not indicated although it was the apparent source of bleeding. At the time of discharge his hemoglobin was 8, reticulocyte count 2.5%, and his stools showed only a small amount of occult blood.

In the office in November his serum iron was near normal, and stool for occult blood was negative. Hemoglobin levels were 11 and 11.5 and eventually increased to normal. Muscle symptoms continued unchanged. In January 1970 his sedimentation rate was 39. Because he was largely incapacitated by his symptoms, the story remained consistent for polymyalgia, and sedimentation rate was moderately high, it was decided that he might be tried on a small dose of prednisone. He was given 10 milligrams of prednisone twice a day for a few days. This was cut to 10 milligrams in the morning and 5 milligrams in the evening. There was an immediate remarkable improvement in all of his symptoms and his sedimentation rate decreased in two weeks from 39 to 8. Prednisone was cut further to a dose of 7.5 milligrams over the next two months and is taken with large doses of antacid. At that time, hemoglobin was normal and sedimentation rate was 7. In view of his continuing good response to minimal doses of prednisone he seems to fulfill the criteria for a diagnosis of polymyalgia rheumatica.

Polymyalgia rheumatica was first characterized about fifteen years ago in England although similar descriptions had appeared in the literature in the 1800's. If defined with care (and not used as a diagnostic waste basket) patients can be found who fill the criteria for diagnosis and are greatly helped by therapy. The diagnosis[10] is suggested[11] by the features outlined in Table III. With questioning, it will be noted that aching and stiffness involve muscles rather than joints and the rheumatoid factor is usually absent. As with most conditions involving muscle, the large muscles around the shoulders and hips are primarily involved. Objective muscle disease is absent. Enzymes are normal. Biopsy is normal. EMG is normal. Systemic symptoms and signs such as fever, weight loss, and mild anemia may be present in varying degree.

TABLE III

Polymyalgia Rheumatica

1. Muscular aching, pain, and stiffness involving primarily the shoulders, neck, and thighs.
2. Absence of arthritis. Test for rheumatoid factor usually negative.
3. Absence of objective muscle disease. Enzymes, biopsy, and EMG normal.
4. Systemic symptoms may be present.
5. Patients usually over 60.
6. Sedimentation rate elevated, usually markedly.
7. Prompt response of symptoms and sedimentation rate to *small* doses of corticosteroid.

Patients are elderly, usually over sixty, and women are more commonly affected. Sedimentation rate is markedly elevated, frequently to 100 or more (Westergen). The response to *small* doses of corticosteroids such as 10 milligrams of prednisone daily is prompt and dramatic both with regard to symptoms and the sedimentation rate. In the elderly man described, a typical history was given although systemic symptoms were minimal. There was no evidence of arthritis. Muscle enzymes were normal. The sedimentation rate was elevated but not markedly so and for this reason there was hesitancy about beginning steroids, especially in a potential gastrointestinal bleeder. In January, 1970, however, sedimentation rate reached its highest level and his activities were severely restricted by his symptoms. Prednisone was given and results were remarkable. In two weeks he came in swinging his arms and kicking up his legs.

Sedimentation rate had fallen from 39 to 8. Prednisone was soon decreased to 7.5 milligrams daily. High prednisone doses will obscure many things. A woman in her early forties was recently seen with muscle aches and a very high sedimentation rate. Her physician suspected polymyalgia and gave her 60 milligrams of prednisone. However, the dose was too high and the patient too young to consider the diagnosis proved. Symptoms returned when her steroid dose was decreased and a month or so later the diagnosis of acute leukemia was made. Steroids should not be given lightly in this or any condition. Patients with non-specific complaints and normal sedimentation rates should not be called polymyalgia and do not deserve even a "trial" of steroids.

Temporal artery biopsies in polymyalgia have disclosed giant cell arteritis in a significant proportion of patients. Since this vasculitis may be associated with blindness, some authors[12] feel that temporal artery biopsy is indicated in all polymyalgia patients.[13] In any case, patients should be carefully examined for this complication and informed to watch for headaches or visual symptoms.

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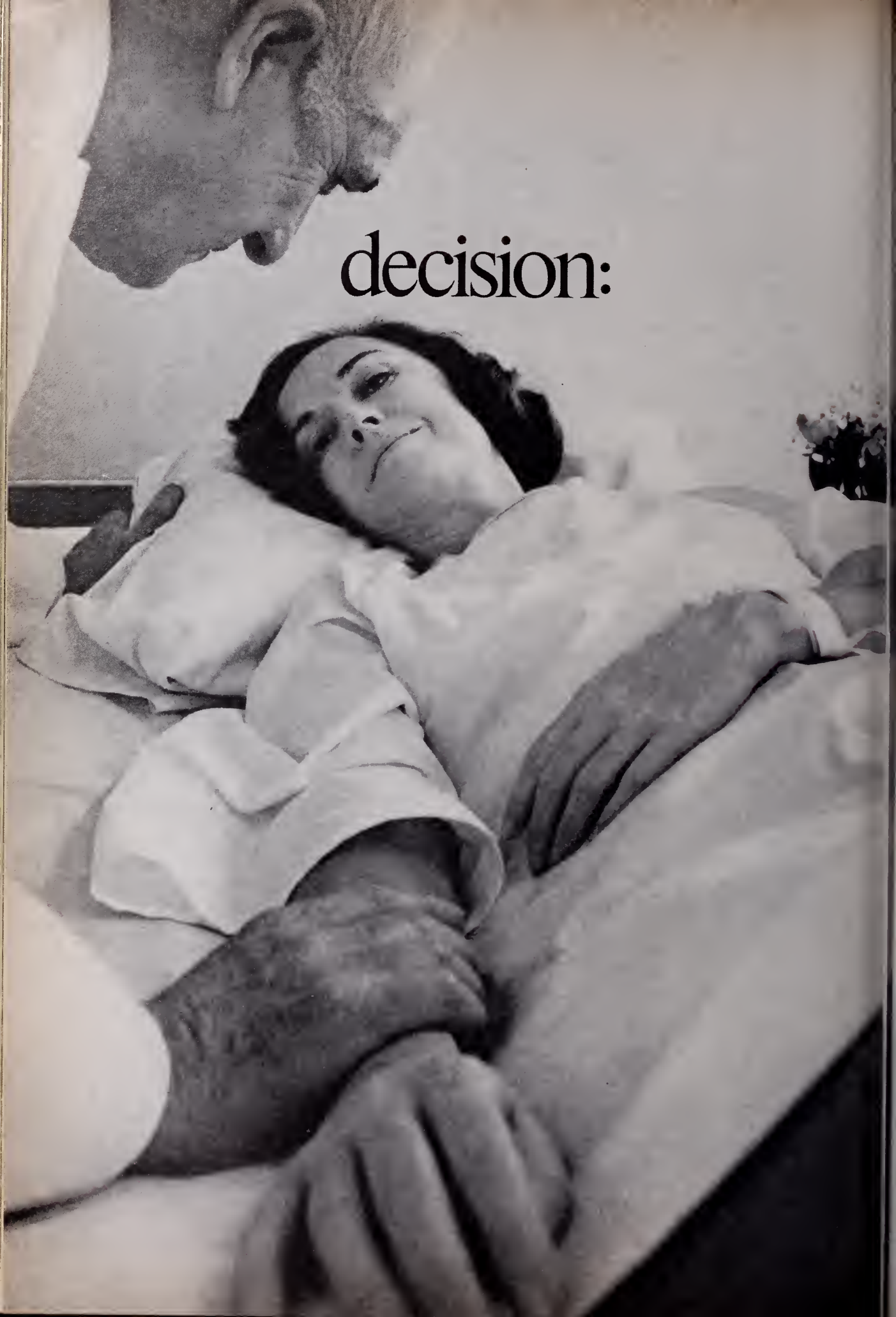
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116 Millburn Avenue

MSNJ Scientific Exhibits

Members of The Medical Society of New Jersey are invited to participate in the Scientific Exhibits at the 205th Annual Meeting, May 15 to 18, 1971. For information and application form, see page 743 of this issue, or contact our Convention Manager, Mrs. Marion Walton, at the MSNJ offices in Trenton.


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Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

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Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

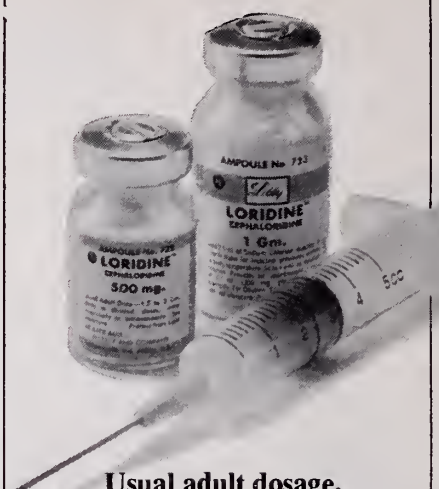
How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

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Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

When a parotitis appears on the same side as an ophthalmic herpes, one wonders if this could be coincidence. What do you think?

Herpes Zoster Ophthalmicus

With Ipsilateral Parotitis; Coincidence or Association?

Frank A. Marshall, M.D./Weehawken

Herpes zoster is a singular disease with usually clear cut, distinctive manifestations of its presence. The prodromal pain comes from acute inflammation of the ganglion of one or more nerve roots. There are succeeding erythematous lesions in which vesicles characteristically develop. Then usually, there is the disappearance of all pain and skin lesions. However, residual neuralgic pains and scars from skin ulcers or sloughs may occur, especially in the elderly.

The intercostal area of herpes zoster is probably the most frequent site. It is occasionally mistaken for angina when occurring on the left side. The most dramatic (and most serious) manifestation occurs with involvement of the ophthalmic division of the fifth cranial nerve at its semilunar ganglion. Why the other portions of this ganglion are not simultaneously involved has been puzzling. Apparently each nerve has a portion of the ganglion, suggesting that, functionally, at least, there are three distinctive ganglia. As with the other forms of zoster, herpes zoster ophthalmicus is nearly always unilateral. While it commonly involves the cornea and conjunctiva (and occasionally the iris), it rarely involves any deeper structures in its area. In the case reported below, parotitis with its moderate enlargement and painful distention appeared simultaneously with the vesicular eruption phase. No skin lesions were evident at the site of the parotid gland, nor could any lymph node enlargement be felt.

A 58-year-old man in apparent good health appeared with complaints of pains of left side of head and forehead. No skin lesions were evident. Physical examination was essentially negative with B P 160/60; and an accentuated second heart sound at A2.

The typical vesicular lesions on an erythematous base appeared five days later, on the left forehead. Simultaneously, he developed ipsilateral swelling of the left parotid gland. Afebrile, his main concern was the discomfort of the swollen gland. The herpes involved the left upper eyelid and forehead and adjacent scalp, but not the eyeball nor its associated muscles. The ear canal and drum were normal. By the ninth day, the gland was smaller and much less painful on a regime of Indocin® and Prednisone®. The vesicles simultaneously subsided. The contralateral parotid gland and testicles were not involved. No contact with any form of epidemic parotitis (mumps) within one month preceding this syndrome was elicited.

Search of the literature has failed to discover a similar case, involving a non-epidemic form of parotitis and herpes zoster. Schley and Bock[1] report a case of concurrent *epidemic* parotitis and herpes zoster (segment, L2) with left orchitis and bilateral parotid gland and submaxillary involvement. They considered this as demonstrating the simultaneous involvement of infection with two viruses (a double viral infection).

My case did not correspond to this, primarily because it is not an epidemic parotitis and thus does not represent an added virus disease. It is a simple case of herpes, with extension to the ipsilateral parotid. It has been suggested[2] that the gland involvement was secondary to lymphatic channel spread from the forehead to the parotid lymph nodes imbedded in the gland. As an alternative, the nerve pathways were judged[3] to be a more likely avenue of its spread, primarily because herpes zoster involves nerves and their ganglia.

The nerve supply of the parotid is complex, including the auricular temporal (5th cranial nerve), greater auricular nerve, and facial (7th

cranial nerve) . . . as well as secretory fibers from the glossopharyngeal (9th cranial nerve).

To fathom any probable interconnection with the ophthalmic division, the most plausible route would be through the roots of the auricular temporal nerve joining the otic ganglion by communicating branches to the parotid. Essentially this would require a wider invasion of the semilunar ganglion, rather than be limited only to the root of the ophthalmic nerve division.

Whatever the explanation, this case did present simultaneous occurrences of non-epidemic ipsilateral parotitis and herpes zoster ophthalmicus with simultaneous subsidence and recovery.

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2202 Palisade Avenue

National Government Formulary Questioned

The American Medical Association opposes establishment of a national formulary that could restrict the prescribing practices of physicians with respect to federally supported medical programs. In this connection, Dr. Ernest B. Howard, executive vice president of the AMA, said:

"The American Medical Association, representing 180,000 active private practitioners of medicine, is opposed to a proposal that would interfere with the professional judgment and responsibilities of physicians. The proposed amendment, which would give a Federal Formulary Committtee the authority to *exclude* from the Formulary (and therefore from payment) any drug which it considers unnecessary is, in our opinion, just such an infringement upon the professional judgment of practicing physicians.

"The amendment would provide the Formulary Committee with authority to publish prescribing information about each drug listed. Adequate prescribing information to assist physicians in selecting the most rational course of therapy is available through a variety of acceptable sources. The proposed additional information is not only unnecessary but undesirable since physicians would be unable to deviate from that standard regardless of a particular patient's circumstances without facing the risk of malpractice liability.

"Further, the amendment would require that a physician who desires to prescribe the product of a particular manufacturer with which he had experience and confidence could do so only by writing in his own handwriting the established name of the drug again and the name of the preferred manufacturer. We disagree with this practice limiting the authority of the physician to prescribe the drug of his choice. The AMA House of Delegates, has reaffirmed on many occasions that physicians should be free to use either the generic or brand name in writing prescriptions.

"The proposed amendment would have the Formulary Committee institute inspections, sample examinations, and scientific review of drug products to be listed by the name of the supplier or the brand name. This task of the committee seems to be beyond its capability, particularly since it is constituted only on a part-time basis.

"We want our patients to receive high-quality drugs at the lowest possible cost. We continue in this position. The creation of a national formulary would *not* bring about a more economical provision of drugs."

Perhaps it is time we took back, from the Boy Scouts and the Red Cross, the emergency care of patients.

Education And Training For Emergency Medical Care

Jack R. Karel, M.D./Hillside*

With the increasing importance of emergency departments, this section may soon be recognized as the most important department of the hospital. The great increase in the volume of patients going or being brought to these departments annually means that demands on physicians in emergency rooms have skyrocketed. Accidents in the home, at work, or on the highways number in the hundreds of thousands. Fortunately, for the country, this condition has not gone unnoticed by medical and governmental agencies[1] and immediate action to improve this situation in emergency departments of hospitals is already underway.

However, what about the physician who has to be called in to the emergency room or who already is working there on a regular or part-time basis? Is he emotionally capable of withstanding the onslaught of a dozen or more victims of a traffic accident or an explosion—all brought to the emergency room at one time? Does he know the meaning of *triage*[2] in the care of mass casualties? Can he suture a simple wound or even do some minor surgery on a face? Does he know what to do immediately for a person brought in with simple chest pain or another gasping for air? Does he know how to establish an airway? Does he understand the principles in the management of multi-system injury? Is he able to do an electrocardiogram on a patient when the regular technician is off duty? After the electrocardiograph record is made, can he detect abnormalities in rhythm? Has he developed enough understanding of the radiogram so that preliminary treatment may be instituted immediately? Is he able to make a quick assessment of an unconscious patient? Does he know what to do with an unruly patient or how to handle a psychiatric emergency?

Unless a physician has had appropriate formal or good in-service training in emergency medical care, he will be unable to cope with the volume of patients that are appearing at emergency departments of hospitals. He will be unable to give the care that people are now expecting. The number of patients appearing at emergency departments is increasing at a rate of over 10 per cent annually and for this the emergency department physician must be prepared.

The time is *now* (not in the distant future) when medical schools must establish curricula pointing toward the education and training of physicians in emergency medical care and the further development of the position of emergency department physician. The need for this kind of doctor is *now* and this need will increase greatly as the years pass by. The American College of Emergency Physicians has recognized this by their formal organization.

As a by-product of this, our country will be that much stronger in medical manpower resources, educated and trained to care for mass casualties, whether from natural or man-made causes.

I strongly recommend that programs in edu-

* Dr. Karel is Emergency Department Physician, St. Elizabeth Hospital, Elizabeth, New Jersey, and Chairman of the Committee on Emergency Medical Care of The Medical Society of New Jersey.

cation and the training of emergency department physicians be instituted immediately in medical schools and in residency programs in hospitals and for the further development of this specialty program.

Reference

1. American College of Emergency Physicians, American College of Surgeons, and Division of Emergency Health Services, U. S. Public Health Service.

2. Triage means sorting of patients in four categories based on severity of injury or illness.

115 North Avenue

The Challenge of Transplantation

Most people think of the first human heart transplant of several years ago as the "breakthrough" in human implantation. Actually, it is 200 years since the first recorded transfer of a part from one human to another. In *The Challenge of Transplantation,* a new Public Affairs Pamphlet, Irving Ladimer outlines developments to date and discusses medical, ethical, social, and financial questions posed by transplantation. The pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, 10016.

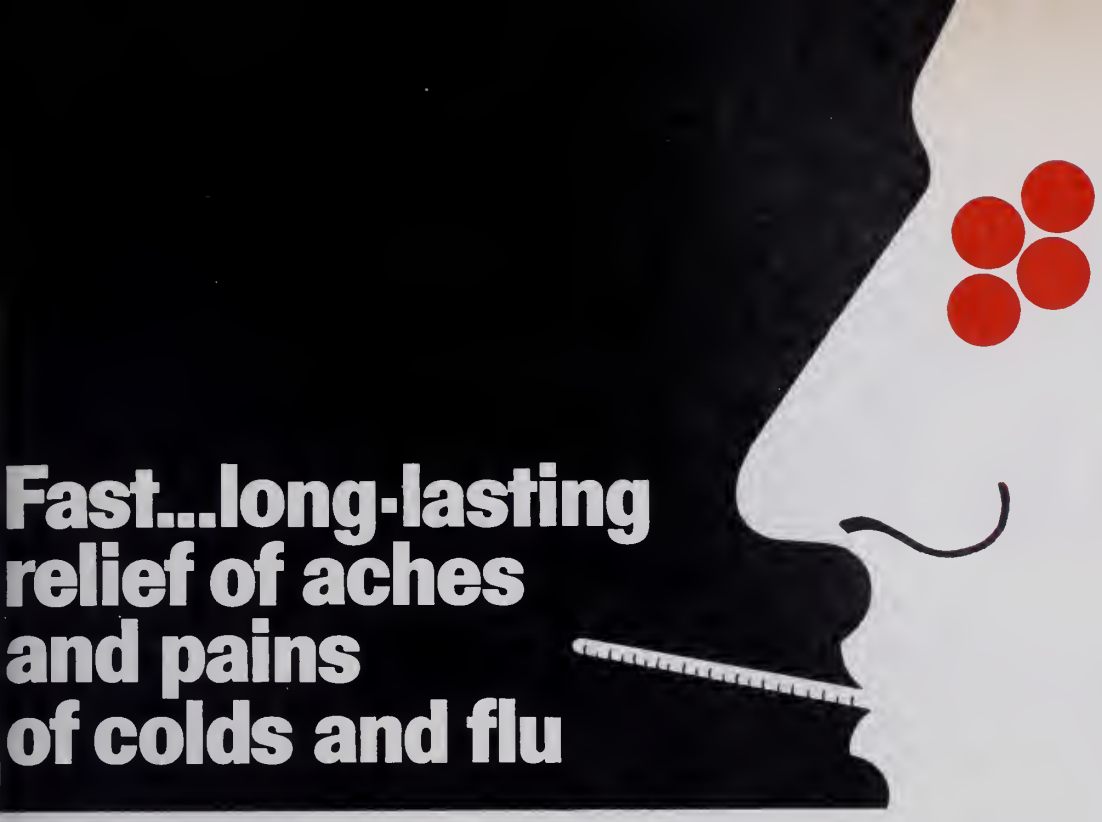
Ladimer reports that "about 25 different kinds of organs and tissues have now been used in human transplantation." The major "obstacle to successful implantation of tissue from one person to another is the organism's rejection of foreign matter. The organism does not distinguish between such an agent and an organ or part which is introduced to help. Finding the answer to the body's rejection response may provide clues to other medical mysteries, such as how to control cancer cells.

Ladimer recognizes the emotional problems that the donee must face: "Before receiving a transplant, the potential recipient must wrestle with his anxiety for himself and also with his feelings for a living donor (of a kidney, for example) whose recovery and well-being are of deep concern to him. After transplantation, the recipient must be able to incorporate the new organ without depression or remorse."

"No physician may assume responsibility unless the rights of both donor and recipient are protected. Each physician must maintain a primary regard for the health of his patient. . . . The death of the donor must be determined by a physician other than a member of the transplant team and must be based on a judgment using all available currently accepted scientific tests. A full discussion with all parties is important, and the interests of advancing science 'must always be secondary to (the doctor's) primary concern for the patient.' Transplants should be undertaken only after careful evaluation of the availability and effectiveness of other possible therapy."

To make possible the gift of human tissue, most states (including New Jersey) have an "anatomical gift law."

An unresolved question is how to make transplantations available to patients whether or not they or the hospital can afford the high costs. While Ladimer believes that eventually "costs can be expected to approximate those of more conventional operations," the National Transplant Information Center is currently advocating special revolving funds so that "if usable organs or tissues are available, candidates for transplantation would not be denied an operation solely because of inability to pay or lack of hospital funds."



Fast...long-lasting relief of aches and pains of colds and flu

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Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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Available: Bottles of 12, 36 and 60 tablets.

Guide his hand to quality and economy



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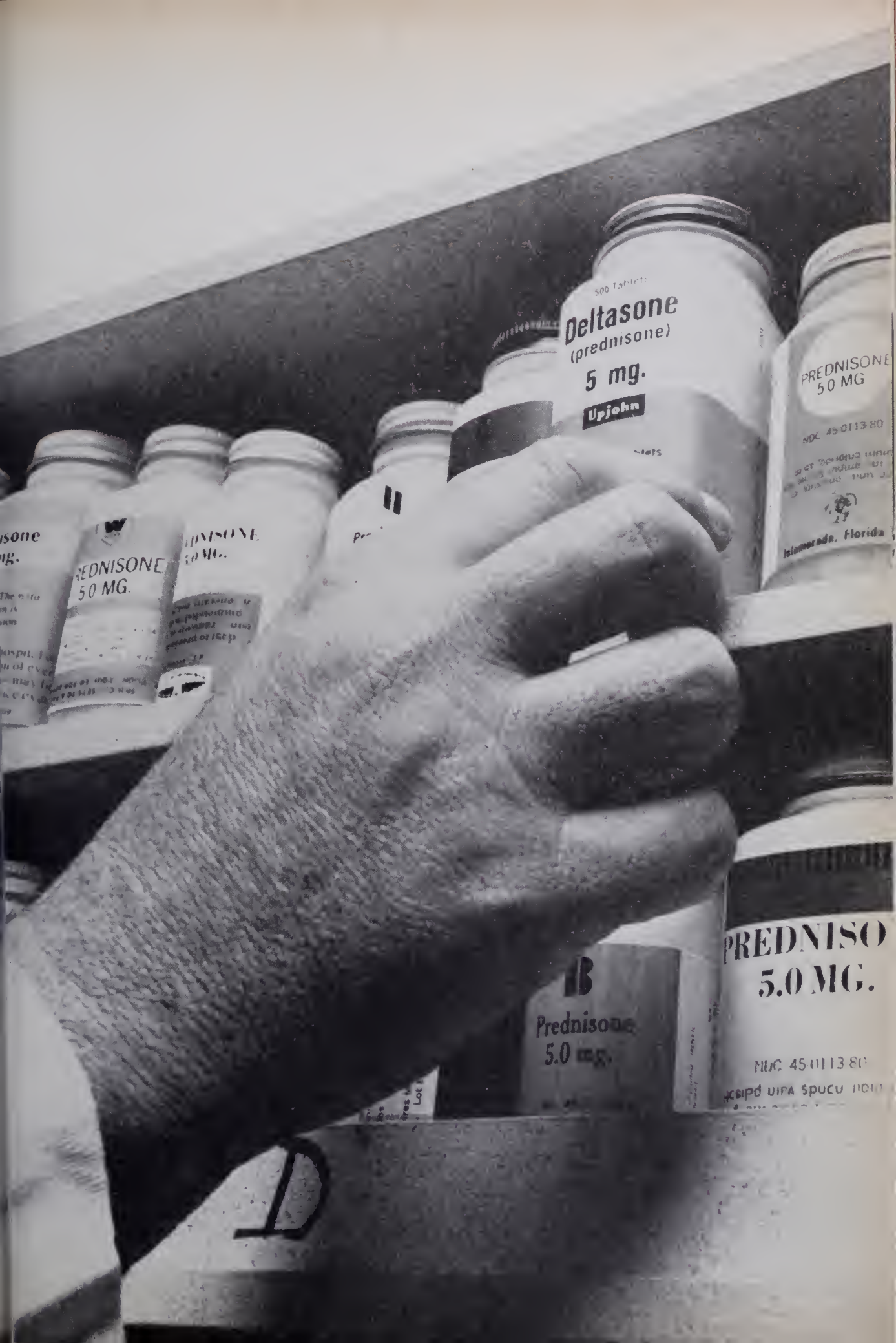
Deltasone® 5 mg.
(prednisone, Upjohn)

an economical prednisone that's made a name for itself

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

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JA70-9779


Deltasone
(prednisone)
5 mg.
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PREDNISONE
50 MG
PREDNISONE
50 MG.
Prednisone
5.0 mg.
PREDNISO
5.0 MG.

DELTASONE® TABLETS—2.5 & 5 mg.
(prednisone, Upjohn)

The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angiitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

Supplied: 2.5 mg., scored—bottles of 100 tablets. 5 mg., scored—bottles of 100 and 500 tablets and cartons of 100 tablets in foil strips.

For additional product information, consult the package insert or see your Upjohn representative.

MED 8-15 1(20-8)

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001



Deltasone® 5 mg. (prednisone, Upjohn)

an economical prednisone that's made a name for itself

The girth control pill



Tepanil® Ten-tab

(continuous release form)

diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur with relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Informotion—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
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Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

September 20, 1970

A regular meeting of the Board of Trustees was held on September 20, 1970 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Cancer Courses—NJRMP . . . Concurred in the action of the President in authorizing the New Jersey Regional Medical Program to list MSNJ as a co-sponsor of four courses on the prevention, diagnosis, and treatment of cancer, to be presented in December and January under the auspices of the NJRMP Council on Cancer.

Psychiatry for the Physician . . . Concurred in the President's approval of the Carrier Clinic listing The Medical Society of New Jersey as a cooperating agency in the presentation of the forthcoming seminar in the Carrier Clinic series on "Psychiatry for the Physician" to be held in October.

MSNJ Representation on AMA Councils . . . Directed that the following names be forwarded to the AMA Executive Vice President, Ernest B. Howard, M.D., as candidates for membership on the Councils indicated:

Legislation	Henry J. Mineur, M.D.
Medical Education	James A. Rogers, M.D.
Medical Services	Nicholas A. Bertha, M.D.
Judicial	Emanuel M. Satulsky, M.D.

Politics and Medicine . . . Authorized the President to appoint a committee to investigate and make recommendations concerning the problem of politics as it relates to medicine in general and to The Medical Society of New Jersey in particular.

Conference of Presidents . . . Authorized the scheduling of the Fall Conference of Presidents and Presidents-Elect of component societies in conjunction with the October 18 meeting of the Board, and designated Dr. Marchione to represent the Board at the morning session of the Conference.

Annual Meeting . . . Approved the following recommendations of the Committee on Annual Meeting:

1. That all exhibits open at 12:00 noon on Saturday, 15 May, and close at 5:00 p.m. on Monday, 17 May 1971.

2. That the Board withdraw its approval of the scheduling of entertainment on Sunday evening, and that the proposed entertainment be scheduled in conjunction with the Exhibitors' Reception-Buffet Dinner on Saturday evening.

Audit by Internal Revenue Service . . . Directed that the following communication from our external auditor, relative to recommendations made by the Internal Revenue Agent following an audit of The Medical Society of New Jersey, be received and filed:

> In my opinion, no change is required in your present set-up. The present system, in effect for a long period, provides the information that you require in an acceptable and understandable manner. The figures required for the tax returns can be easily abstracted from the books and records and accumulated on a worksheet in order to facilitate the preparation of the tax forms. These worksheets should be attached to your office copy of the tax returns, so that an agent or anyone else can easily trace the composition of the figures submitted.
>
> If you were to attempt to make the books reflect the figures as reported to Internal Revenue on Form 990-T, then the dues revenue and various budgetary expenses would be reallocated to "Journal" operations. Therefore, the operations of the Society would not be reflected in accordance with the adopted budget. The Society could adopt, of course, a separate "Journal" budget if deemed necessary.

Principal Field Physician . . . Directed that Commissioner Cowan (Department of Health) be notified of MSNJ's approval of the Department's proposal to appoint Morton L.

Poyas, M.D. to the post of principal field physician to investigate and report to MSNJ's Committee on Maternal and Infant Welfare concerning maternal deaths throughout the State.

AMA Clinical Convention . . . Authorized the following to attend the AMA Clinical Convention in Boston, November 29 to December 2, with expenses paid at a per diem of $50: President, President-Elect, Executive Director, seven regular delegates, and six alternate delegates.

NJCMD Community Mental Health Program Is Funded

The New Jersey College of Medicine and Dentistry's Community Mental Health program has been awarded a staffing grant of $1,276,025 from the National Institute of Mental Health. The funds will be used to recruit, employ, and train staff for the first year of the program as soon as alterations in NJCMD facilities for the program are completed. Additional funds approved for expenditure extending over a five-year period bring the total to $3,991,874, the amount requested in the college's application. "The College," explained Dr. Cadmus, "is deeply appreciative of the federal government's recognition of the critical needs of Newark's inner city by funding our request in full, despite the present limited finances for the National Institute of Mental Health."

Dr. Cadmus added, "The College is indeed fortunate to have Dr. C. Knight Aldrich as director of the new program." Dr. Aldrich is professor and chairman of the department of psychiatry at the medical school.

"The College and other community organizations felt that the need for mental health care in Newark was too great to wait until the proposed Martland Community Mental Health Center was constructed," said Dr. Aldrich. "Therefore, we applied for a grant to finance staffing before the proposed Center was built, and decided to use resources and facilities already in the community. The federal government agreed with our evaluation and so we will employ the new staff in existing facilities where we can begin to improve services. That way, too, there will be a working nucleus of trained personnel ready when the Center is completed."

The College's program has a service area of approximately 200,000 people, and is the only such demonstration project in New Jersey operated in conjunction with the State Department of Institutions and Agencies. Most of Newark residents are being served by the Mount Carmel Guild Community Mental Health program, which has just completed its first year of operation. The only other such program funded in New Jersey is operated by the Hackensack Hospital.

Four local mental health facilities will join together to provide continuity of care through a program of comprehensive mental health services. NJCMD's Martland Hospital will supply in-patient and emergency services, and consultation-education programs will be organized at the College's Interim Campus across from the hospital. Prospect House in East Orange will furnish partial hospitalization for an increased number of Newark residents as a result of the grant, and Newark's Youth Development Clinic, providing out patient care, will extend its services to adults. Patients may be referred to the Essex County Hospital Center and to the Trenton State Hospital.

More than one-half of the staff will be non-professionals from the Newark area. These people will include mental health technicians, patient expediters, nurses' aides, dietary aides, occupational therapists' aides, homemaker aids, ward clerks, and secretary-receptionists, who will receive in-service training. As they will be recruited from the service area, they will help the professionals bridge the gap with the community.

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of Filing: September 22, 1970.

2. Title of Publication: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

3. Frequency of issue: Monthly.

4. Locotion of known office of publication: 315 West State Street, Trenton, New Jersey 08618.

5. Locotion of the headquarters or general business offices of the publishers (Not printers): 315 West State Street, Trenton, New Jersey 08618.

6. Nomes and addresses of publisher, editor, and managing editor: Publisher, The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey; Editor, Henry A. Davidson, M.D., 315 West State Street, Trenton, New Jersey; Assistant Editor, Mrs. Marjorie Treptow, 315 West State Street, Trenton, New Jersey.

7. Owner (If owned by a corporation, its name and address must be stated and olso immediately thereunder the names ond addresses of stockholders owninq or holding 1 percent or more af total amount of stock. if not owned by a corporation, the names and oddresses of the individuol owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as thot of each individual must be given.): The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, ond other security holders owning or holding 1 percent or more of totol amount of bonds, mortgages or other securities (if there are none, so state): None.

9. For completion by nonprofit organizations authorized to moil at special rates (Section 132,122, Postal Manuol). The purpose, function, and nonprofit stotus of this organizotion and the exempt status for Federol income tax purposes have not changed during preceding 12 months.

10. Extent and nature of circulation.

	Average No. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Totol No. copies printed (Net Press Run)	8,625	8,600
B. Paid Circulation		
1. Soles through deolers ond carriers, street venders and counter sales	—	—
2. Mail Subscriptions	8,136	8,156
C. Total Paid Circulation	8,136	8,156
D. Free Distribution (including samples) by mail, carrier, or other means	342	324
E. Tatal Distribution (Sum of C and D)	8,478	8,480
F. Office use, left-over, unoccounted, spoiled ofter printing	147	120
G. Totol (sum of E & F should equal net press run shown in A)	8,625	8,600

I certify that the statements made by me above are correct ond complete.

Robert H. Lombert
Business Manager
The Medicol Society of New Jersey

The Scientific Exhibits — — 205th Annual Meeting

The following information is pertinent to the scientific exhibit display at the 205th Annual Meeting of this Society, May 15 to 18, 1971. Those interested in participating may use the application form on page 743. (Please complete both sides.) Remove the page from *The Journal* and mail directly to Arthur Bernstein, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Policy—It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey, in instances where a pharmaceutical company has aided in the production of an exhibit—either through financing or supplying products—that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints or articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

Space assigned will be a drapery booth consisting of a backwall and two sidewalls. Each booth is 6 feet deep. The backwall will vary according to the requirements of the exhibitor, and the measurement must be noted on the application. A shelf one foot wide is provided with each booth. The height of the wall above the shelf is 5 feet, 6 inches. However, the shelf will be removed if advance request is made. By eliminating the shelf, the booth will measure 8 feet in height.

Please indicate on the application if the exhibit is free-standing. Such an exhibit will not require a drapery booth.

Please indicate on the application if a sign is incorporated with your exhibit. If so, one will *not* be ordered.

If at all possible, a photograph of the exhibit should accompany the application. If a photograph is not available, a drawing will suffice.

Application for space in the Scientific Exhibit must be submitted no later than January 1, 1971, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send *completed* application, together with photograph or drawing of exhibit to Arthur Bernstein, M.D., Chairman, Committee on Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton. 08605.

1. *Time:* The exhibits will open officially at 12 noon, Saturday, May 15, and close at 5 p.m., Monday, May 17. On the intervening day the hours are 9 a.m. to 5 p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 3 p.m., Friday, May 14, and all exhibits must be in place by 11 a.m., Saturday, May 15. Exhibits must remain intact until 5 p.m., Monday, May 17, and should be removed from the exhibit hall not later than 12 noon, Tuesday, May 18.

3. *Cost:* The Society provides free of charge such space exhibitor may require, including booth with shelf, printed sign *(if requested)*, and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, *including electrical connections.*

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent.* The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorses nor assumes any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of all exhibitors will be deeply appreciated.

THE MEDICAL SOCIETY OF NEW JERSEY

205th Annual Meeting

HADDON HALL ATLANTIC CITY, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 15-17, 1971

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use *typewriter,* or *print,* please)

1. TITLE (Generic names only): .....

.....

Full Name and Degree of Exhibitor(s) .....

.....

City ..... State .....

Institution (if desired) ..... City .....

Aided by commercial or pharmaceutical company .....

Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

.....

.....

.....

.....

.....

3. Is the exhibit free-standing or self-contained? .....
4. SIGN required: ..... SIGN *not* required: .....
5. Will backwall and dividers be required? (see sketch on reverse side): .....
6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15', depth 6'.

   Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear blackwall .....
7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. .....
8. Has this exhibit been shown in whole or part at any other scientific meeting? .....

   If so, when? ..... and where? .....

The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: ....

Return application to Arthur Bernstein, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

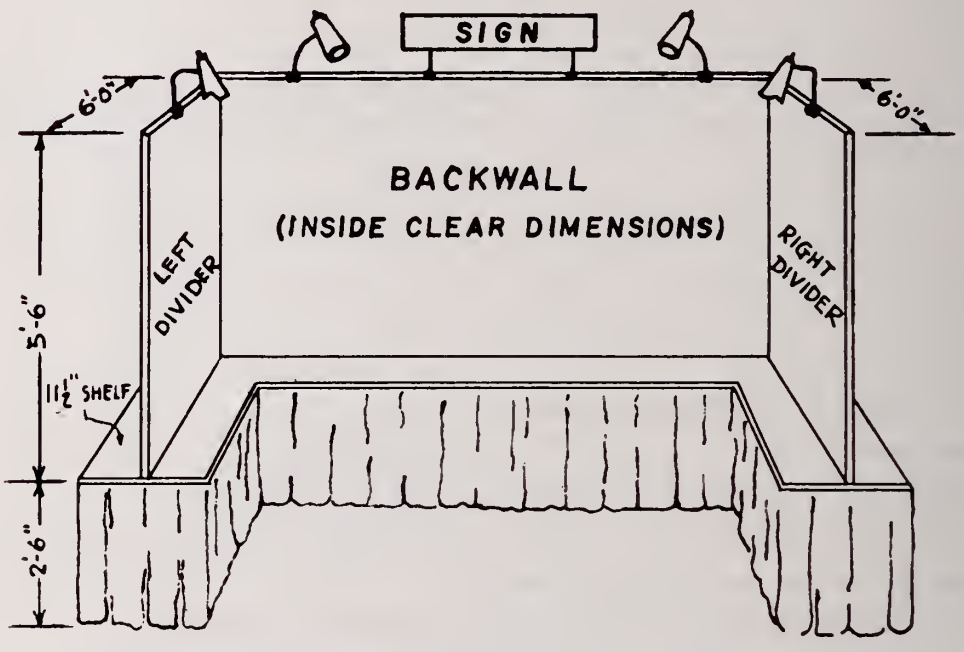
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
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The AMA Dues Increase

The American Medical Association's House of Delegates, in June, approved a $40-a-year increase in AMA dues, raising them to a total of $110 a year. To determine the need for the increase, the *American Medical News* conducted interviews with Max H. Parrott, M.D., chairman of the Board of Trustees, and Burt L. Davis, M.D., chairman of the Finance Committee of the Board. Following is the first of a series based on those interviews.

Q. Dr. Davis, what were the factors leading the Board to ask for a dues increase this year?

A. To oversimplify, it became apparent that we couldn't live within our income at the present level. In fact, we're operating at a deficit this year. Actually, it was a combination of things—inflation, fiscal uncertainties in the future, and the need for more and better AMA programs in the years ahead. Inflation is affecting the AMA about 6 per cent a year. Perhaps that doesn't sound like much, but when you start talking about dollars, you come up with some alarming figures. Our operating expenses this year are estimated at $32,024,955, that's including about $25 million for programs, $1.5 million for costs of occupancy, including property taxes, and $6.7 million in administrative costs. In 1967—the last year dues were raised—operating expenses were $28,371,000, with $21,411,000 for programs, $1,285,000 for occupancy, and $5,675,000 for administration. Now, if you figure the 1967 costs in 1970 dollars, the programs for that year would have cost $32,910,000—more than they're going to cost this year.

Q. Do things look any better in the future?

A. If inflation keeps on at its present pace, it will add nearly $2 million to our costs in 1971, and another $2.25 million in 1972. These figures don't include any provision for taxes on our "unrelated business income"—the status of which is still in doubt—nor do they include expansion of our programs and activities.

Q. What effect is this having on AMA activities?

A. We've had to do some curtailing, of course. As an example, in 1967, one of our important councils held eight meetings for a total cost of $30,000. This year, that same group will meet only seven times, and it'll still cost $38,000.

Q. What about the non-controllable costs?

A. Such things as postage and taxes are controllable by the government—there's not much we can do about it. This year the AMA will pay $325,000 to the government as its contribution to Social Security for its employees. These taxes have gone up 19 per cent since 1967. Postage is another big item for us, and the postal rate increases have had a definite effect. These are the kinds of costs we can't do anything about—when they go up, we have to pay the increases.

Q. What about salaries?

A. As AMA programs expand, more people are required to staff them. And salaries have to keep going up or the high-caliber people we want won't be able to work for us. In 1967, we had 982 employees, today just over 1,000 but the number of professional people has increased 13 per cent. Three years ago, our total payroll was $8.4 million; this year it'll be just over $11 million. And we'll pay $1,081,000 in benefits—including Social Security—whereas the total was $905,000 in 1967. We're doing everything we can to hold payroll costs down. But our increasing involvement in major programs makes it necessary that we hire more and better professional people for the staff.

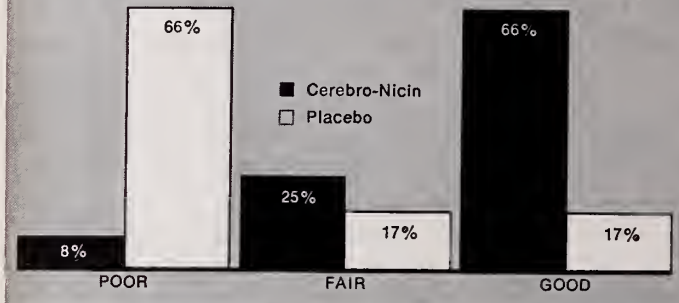
In figuring our future needs, we included an 8 per cent inflation factor in all salary estimates. Many unions have won contracts calling for much bigger increases. Major union settlements during the first half of the year included a median increase of 9.7 per cent a year in wages and benefits. For most of the other items in the AMA budget, we used an inflation factor of 5.8 per cent a year.

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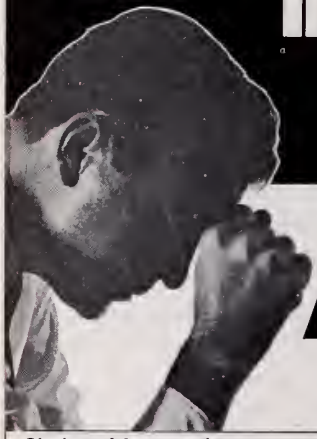
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Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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Contraindications—Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tifft, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Heilman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and isothyroxine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during September 1970:

	1969 September	1970 September
Aseptic Meningitis	59	68
Primary Encephalitis	6	2
Post-Infectious Encephalitis	0	0
Hepatitis: Total	203	277
Infectious	169	220
Serum	34	57
Malaria: Total	16	7
Military	11	4
Civilian	5	3
Meningococcal Meningitis: Total	3	5
Military	0	2
Civilian	3	3
Mumps	22	30
German Measles	11	1
Measles	11	7
Salmonella	66	66
Shigella	27	3

Influenza Vaccine: Here is the recommendation of the Public Health Service Advisory Committee on Immunization Practices. This is abstracted from *Morbidity and Mortality Weekly Report,* 19:327, August 22, 1970.

Inactivated vaccines have been variably effective and have offered brief periods of protection against influenza. Control of epidemic influenza in the general population is not possible through routine vaccination. Their selective use, however, can be justified for chronically ill patients of all ages and for older persons in the population. Individuals in both groups are characteristically at greatest risk of serious complications or death from influenza or its complications.

Forecasts of expected influenza activity may have led to the misunderstanding that vaccines should be employed *only* in years when epidemics are predicted. However, some influenza A or B cases occur in the United States each year, although their frequency and geographic extent vary widely. Annual vaccination of *all* individuals for whom influenza would be a significant hazard is recommended regardless of the expected occurrence of influenza in any area.

Influenza Virus Vaccines: For 1970-71, the composition of the vaccine remains the same as the bivalent vaccine recommended for 1969. The adult dose of inactivated influenza vaccine contains 400 chick cell agglutinating (CCA) units of type A2 antigen (A2.Aichi/2/68) and 300 CCA units of type B antigen (B/Mass/3/66). Highly purified vaccines (available from most manufacturers) are equivalent in potency to earlier vaccines, but contain less non-viral protein and are the recommended products where available.

Recommendations: Annual vaccination is recommended for persons of all ages who have chronic debilitating conditions: (1) congenital and rheumatic heart disease, especially mitral stenosis; (2) cardiovascular disorders such as arteriosclerotic and hypertensive heart disease, particularly with evidence of cardiac insufficiency; (3) chronic bronchopulmonary diseases, such as asthma, chronic bronchitis, cystic fibrosis, bronchiectasis, emphysema, and advanced tuberculosis; or (4) diabetes mellitus and other chronic metabolic disorders.

Older persons who may have incipient or potential chronic disease (particularly those affecting cardiovascular and bronchopulmonary systems) should also be considered candidates for annual vaccination.

Immunization of persons involved in providing essential community services may also be considered. Here, physicians must take into account a number of factors including: the difficulties inherent in prediction of influenza epidemics, the variability of vaccine effectiveness, the incidence of side reactions, the cost of the programs, the availability of the vaccine, and the diversion of existing vaccine supplies from those with chronic debilitating conditions who are at high risk.

Vaccination Schedule: The primary series consists of two doses administered subcutaneously, preferably 6 to 8 weeks apart. Persons who had one or more doses of the vaccine containing Hong Kong strain antigen in 1968, 1969, or 1970 require only a single subcutaneous booster dose of bivalent vac-

cine. All others should receive a primary series. Vaccination should be scheduled for completion by mid-November.

Precautions: Influenza vaccine is prepared from viruses grown in embryonated eggs and ordinarily should not be administered to persons with a history of allergy to eggs.

If clusters of cases of influenza occur during the forthcoming winter months, your Communicable Disease Control Program would appreciate notification by telephone at (609) 292-7300, in addition to reporting to local health officials.

North Jersey's Regional Medical Library

On July 1, 1970, the New Jersey College of Medicine and Dentistry became the Regional Medical Library for the northern New Jersey area under a contract signed with the New York Academy of Medicine Library. The New York Academy of Medicine Library has been designated Administrative Center of a decentralized region by the National Library of Medicine.

NJCMD was chosen to be the Northern Regional Library under contract with the New York Academy of Medicine Library because of its record of achievement and experience in inter-library loan service. Dr. James E. McCormack, Director of the New York Academy of Medicine Library, said, "The choice was an obvious one. NJCMD has been handling inter-library loans for several years and is oriented in that direction of community service."

The contract appoints NJCMD to serve as the Regional Medical Library for the eleven northern counties of New Jersey (Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union, and Warren). NJCMD will provide up to 300 free inter-library loans per institution per year and will refer unfilled inter-library loan requests to the New York Academy of Medicine Library, the National Library of Medicine, or other Regional Medical Libraries. The other cooperating Regional Medical Libraries also under contract to the New York Academy of Medicine Library are the Upstate Medical Center Library at Syracuse, which will serve the upstate New York area and the Medical Research Library of Brooklyn, which will serve the Metropolitan and Long Island, New York area.

Inter-library loan services given by all four libraries will be available on an equal access basis to all qualified public and private institutions with programs of health professional education, service, or research above the secondary school level. A reasonable amount of service will be given to individual health professional users who have no library service.

Inter-library loans mean that libraries will borrow from one another when requested material is not at their own library. NJCMD's library makes available for inter-library loans a collection of 50,000 volumes and includes 2,000 current periodical subscriptions. The periodical is the basic tool for medical research.

AMA Offers "No Smoking" Signs

Growing numbers of non-smokers are objecting to the gratuitous pollution inflicted upon them by tobacco users. To avoid possible confrontations between the two factions in physicians' reception rooms, the American Medical Association is offering desk-top signs and wall plaques; the former asks "NO SMOKING PLEASE" and the latter announces, "For The Sake Of Your Health And The Comfort Of Others—No Smoking Please." Sign prices are 95¢ *each* for five or more, and $1.25 for up to four signs; the plaques are $1.50 each up to four, and $1.20 for larger quantities. Orders from medical societies enjoy a 50 per cent discount.

Drug Abuse Education

The National Medical Association and the American Medical Association, through their Joint Committee on Health Problems in Education, adopted a resolution on June 10, 1970, calling for more attention to the training of teachers in educating school children about drug abuse. In this connection, the Essex County (New Jersey) School System has developed the following "guidelines" to such programs. The coordinator of the program is Sylvia Herz, Ph.D., whose article on drug abuse appeared in the January 1970 issue of *The Journal*. Together with Simeon Moss, Essex County Superintendent of Schools, these "guidelines" were prepared, and the items of interest to our physician readers are abstracted below.

The committee is aware that the drug problem cannot be totally resolved within the education community. The availability of drugs is not limited to the high school, but has penetrated to the elementary school level as well. An awareness of the drug problem by school administrators, and their active efforts to share with both parents and community a responsibility for a positive approach to its solution, should be our first step in grappling with this social epidemic.

There are many self-styled authorities on drug abuse. We recommend caution in the selection of speakers regardless of whether or not they are paid for their services. No matter how well-intentioned or informed they may be, many speakers by their approach tend to "turn students on to drugs" rather than "turning them off." A speaker who is highly authoritarian or rigid in his presentation should be avoided. Students do not respond to this type of speaker and profit very little from, what, in many other respects, might be a good presentation. Appeals to students by speakers based on fear, the illegality of drugs, or the harmful effects of drugs on the body have usually proved to be ineffectual. Punishment by incarceration alone is not a solution to the drug problem as evidenced by the high rate of recidivism among drug offenders.

A person with a basic knowledge of the drug scene with its attendant socio-cultural causative implications, who can gain rapport with students by effective presentation of material which has student appeal, and develops confidence and mutual rapport, is the type of speaker to be sought.

There is little evidence to support the thesis that drug education alone will stop its abuse. Moreover, most studies have indicated that students are generally well informed on drugs, their properties, and the effects upon abuse. It is recommended that before exposing a large segment of the pupil population to a speaker, film, posters, or literature on drug abuse, a pilot study be conducted with a small group of students. Student reaction from this smaller group can be secured by asking the following questions:

a. What did you think of the speaker, film, (etc.)?
b. Did you learn anything that you did not know before? What?
c. Do you agree with the message that the speaker, film, etc. conveyed? Explain.
d. Do you feel differently about drugs as a result of your exposure to the speaker, film, etc? If yes, what is the difference?
e. How do you think the rest of the group reacted?

After its value has been properly assessed, all speakers, films, literature, etc. should be subjected to immediate follow-up. Follow-up can best take the form of small group discussions with as little formal leadership (either by staff members or students) as possible. Purpose of the small group discussions should be to stimulate as much interchange between students as possible after the *formal* presentation has been made. From such discussions there may evolve student groups that will take a strong stand against drugs. There is already such a junior high school student group being formed called "Not Me" which originated in West Orange. This excellent development lessens the peer group pressures to conform to drug usage and makes available a positive sub-group to which a student can develop a sense of belonging.

"Rap Sessions" among secondary and junior high school students where they ventilate a

multiplicity of problems—family, education, social, sexual—should be encouraged in a non-authoritarian, free discussion type of setting. These sessions should take place during free periods or at other appropriate times during the school day. This technic appears to be the most effective appeal to young people, since it provides a forum for the ventilation of the multiple frustrations of youth through open and free expressions. It helps students realize that their "problems" are not unique. Often they get a clearer insight into their own grievances as they objectively listen and assist their peers in solving their problems. Personal growth is fostered through this process of group dynamics.

It is suggested that the students themselves could select a rapport-creating faculty member (teacher, guidance counselor, nurse, etc.) to sit in on their discussions. With training, senior high school students might be used as leaders of junior high groups, and junior high students could lead an elementary group. Such group interactions would offer the advantage of age proximity in peer relationships. An open ended course which will provide the essential human relations elements for coping with youth's perplexities (growing up, overcoming the difficulties of "making it" in today's world) might become part of the required curriculum of the public schools. A course of this type would be unstructured except for stated goals. To be fully effective, parents must be involved in separate and later in coordinated parent-teacher-student workships, not only to open channels of communication among all groups, but also to better enable each group to assist the other in life-style functioning and in their varied interrelationships.

Students must be heard. We must offer to them a means for direct communications with us. Barriers that have been raised which have created impersonal relations among the child, his parents, and the community, and with it hopelessness and alienation, must be struck down. We must recognize that drugs are a "symptom" of our times in an already pill-drug-oriented culture. It offers to our youth an escape from reality in our highly competitive multi-problem-faceted and nuclear space-oriented society.

Alternatives to drugs for young people should be offered in challenging aspects of living by personal contribution to society in a meaningful way. It is recommended that immediate lines of communication be opened among parent, child, and school, and that referrals be made when it is apparent that a child is using drugs.

Where the teacher first becomes aware of the student's involvement with drugs, the parents should be informed.

Where a parent seeks the teacher or school's assistance when she is first to discover that her child is a drug user, counseling should be given to the parent by the school.

When faced with a problem of drug abuse, school personnel should recognize that there is a difference between drug experimentation and the serious hazards of drug addiction. There should also be awareness on the part of educators that there is a difference in the treatment accorded. There has been wide dissemination in the literature and by the communication media on the types of drugs. No attempts will be made here to categorize the "soft drugs" (marijuana, amphetamines, barbituates, LSD, etc.) or the "hard core narcotics" (heroin, opium, cocaine, opiates, etc.) with their respective properties and effects upon abuse. This information is easily attainable.

Accurate and informative literature on drug abuse can be obtained from many agencies. Recommended selected readings on Drugs and Drug Abuse are listed below:

Drug Dependence: Its Significance and Characteristics—Single copy free from Bureau of Narcotics and Dangerous Drugs, 1405 I Street, NW, Washington, D.C. 20537.

What You Should Know About Drugs and Narcotics—Associated Press, 50 Rockefeller Plaza, New York, N.Y. 10020. $1.00 single copy.

Drug Abuse Education: A Guide for the Professions—American Pharmaceutical Association, 2215 Constitution Ave.. NW, Washington, D.C. 20037. $1.00 single copy.

The Courier—The UNESCO Magazine. May 1968 issue. UNESCO Publications Center, U.S.A., 317 E. 34 Street, New York, N.Y. 10016. Single copy 50¢.

Drugs on the College Campus—National Association Student Personnel Administrators, International Inn, Suite 405, 5440 Cass Ave., Detroit. Michigan 48202.

What We Can Do About Drug Abuse—Public Affairs Pamphlet #390, Public Affairs Pamphlets, 381 Park Avenue South, New York, N.Y. 10016. Single copy 25¢.

Drug Abuse: The Empty Life—Smith, Kline & French Laboratories, Bureau of Narcotics and Dangerous Drugs, 1405 I St., NW, Washington, D.C. 20537. Single copy free.

"Drug Menace: How Serious"—*U.S. News and World Report*, May 25, 1970, pp. 38-42.

Drug Facts—Booklet produced by AT&T, April 1970. Copies available through Public Relations Dept. Western Electric Company, Newark, New Jersey.

You may also get directly from Dr. Herz, 220 Tillou Road, South Orange 07079, a reprint of her paper on "Behavior Patterns on the College Campus," published in the January 1970 issue of this *Journal*. The following brochures are obtainable from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402:

Drugs of Abuse—Reprint from August 1970 issue of FDA papers. 20¢ each.

LSD: The False Illusion—Reprint from August issue of FDA papers. 15¢ each.

Drugs and Your Body—FDA Pub. 52—$1.00 each.

Handbook of Federal Narcotic and Dangerous Drug Laws—Bureau of Narcotics and Dangerous Drugs publication. 50¢ each.

Community-Based Treatment Programs for Narcotic Addiction—Public Health Service publication. 5¢ each.

The Up and Down Drugs—Public Health Service Pub. 1828. 5¢ each.

Marijuana: Some Questions and Answers—Public Health Service Pub. 1829. 5¢ each.

LSD: Some Questions and Answers—Public Health Service Pub. 1828. 5¢ each.

Narcotics: Some Questions and Answers—Public Health Service Pub. 1827. 5¢ each.

Traffic in Opium and Other Dangerous Drugs—Annual Report of Narcotics and Dangerous Drugs. 40¢ each.

Narcotics and Drugs—A list of 58 publications concerning drugs from government agencies that are "sale" items from the GPO. Single copy free.

LETTER TO THE JOURNAL

We're Polluted Too

September 22, 1970

Dear Doctor Davidson:

Your editorial in the September issue repeats the following, which may have been true ten years ago—"The adverse effect of air pollution on the general health has been based on several severe episodes of community-wide pollution and specific exposures under industrial conditions, *but practically no valid epidemiologic studies and little experimental data are available.*"

Go through *Air Pollution Abstracts* for the past ten years. You will see thousands of experimental data reports and hundreds of valid epidemiologic studies from all over the world--many from the highest echelons of research. Overexposure to polluted traffic air, for example, causes serious injury to the heart and brain according to recent reports in reputable scientific journals.

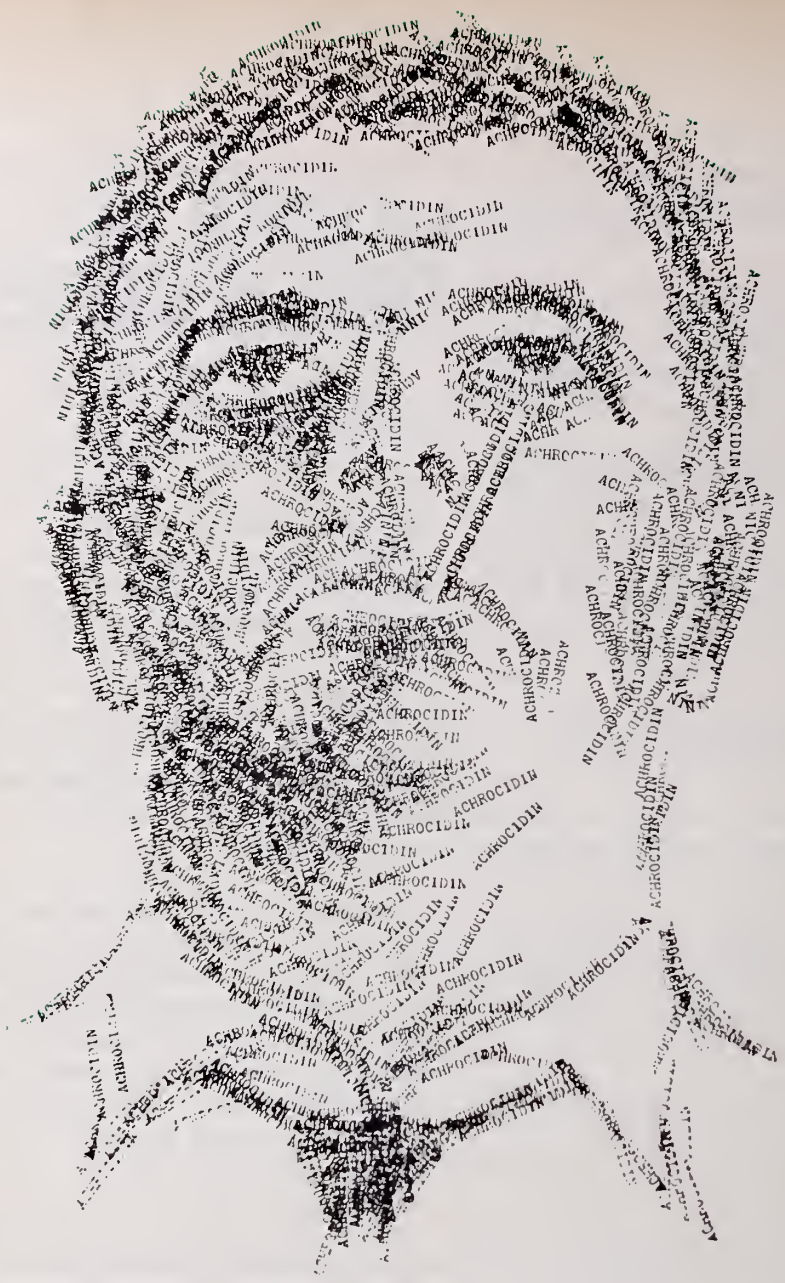
Errors of fact like this can do irreparable harm to those of us who are trying to do something about the air pollution problem. Legislators read these statements and assume that further study is necessary before they can appropriate money or pass stronger laws to control air pollution.

(signed) Frank L. Rosen, M.D.

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ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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535-9

ANNOUNCEMENTS

Chemotherapy In Malignancies

Available to you is a practical course in chemotherapy for malignant disease. This is given in Somerville, in the center of our state. Sessions are held on Wednesdays from 3:30 to 5 p.m. at the Somerset Hospital on Rehill Avenue. November 5 is devoted to chemotherapy of lymphoreticular diseases. On November 12, the topic will be chemotherapy in mammary and gynecologic carcinomata. On December 3, the topics will be chemotherapy in lung cancer and gastrointestinal tumors. The December 10 meeting will be divided between chemotherapy in tumors in children and genitourinary tract malignancies. The session on December 17 will focus on immuno-suppressive agents and on current trials of chemotherapeutic medications. A star-studded faculty of experts has been recruited. For more details, write to Brewster S. Miller, M.D., Somerset Hospital, Somerville 08876.

Clinical Application Of Basic Sciences

The Burlington County Memorial Hospital series on clinical application of the basic sciences has arranged the following programs for December:

December 3	Intensive Radiation Therapy
December 10	Antimicrobial Agents
December 17	Interservice Seminar

The sessions are held on Thursday afternoons at 3:30 in the Common Room of the T. J. Summey Building of the hospital. Please contact the Department of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060, for further information.

The American Academy of General Practice gives one and a half credits per session.

Maternal and Child Health Fellowship

Graduate programs leading to the degree of Master of Public Health are available for pediatricians, obstetricians, and other physicians interested in the field of maternal and child health. This program is given at the School of Public Health of the University of California in Berkeley, and applications are now being accepted for the group entering in September 1971. For further information write to Helen M. Wallace, M.D., Professor and Chairman, Division of Maternal and Child Health, School of Public Health, University of California, Earl Warren Hall, Berkeley, California 94720

Proctologists Meet In Mexico

February 26 to March 5, 1971 are the dates and Mexico City is the place of the next teaching seminar of the International Academy of Proctology. The program is built around what the non-proctologist can do and should know about disorders of the colon, rectum, and lower bowel. For a program, write to Alfred J. Cantor, M.D., International Academy of Proctology, 147-41 Sanford Avenue, Flushing, New York 11355.

Cryosurgery in 1971

The Society for Cryosurgery holds its next scientific program from March 1 to March 5, 1971 at the Diplomat Hotel in Hollywood, Florida. All interested in cryosurgical procedures are invited to attend. Make your reservation now.

Cryosurgery in the following specialties will be discussed: general surgery, dermatology, gynecology, neurology, ophthalmology, otolaryngology, and urology.

For further information write: Secretary, Society for Cryosurgery, 30 North Michigan Avenue, Chicago, Illinois 60602.

Surgical Congress In Africa

The Third International Congress on Ophthalmic and Otolaryngic Plastic Surgery will

be held in East Africa—Kenya, Uganda, and Tanzania—March 13 to 28, 1971. Scientific sessions will be at the University of Kenya in Nairobi. For information, write to Ralph Dicker, M.D., 395 West Blackwell Street, Dover, New Jersey.

Otolaryngology: 1971

The Department of Otolaryngology of Jefferson Medical College (Thomas Jefferson University, Philadelphia) announces a graduate symposium April 1 and April 2, 1971. Theme will be "Therapy in Otolaryngology—1971." It focuses on both medical and surgical treatment and includes otology, rhinology, sinus disease, allergy, head and neck cancer, trauma, and maxillofacial surgery. Registration fee of $50 for practicing physicians and $10 for residents will include lunches on both days, and a dinner meeting. For further information, write to William H. Baltzell, M.D., Department of Otolaryngology, Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

Orthopedic Fellowship Competition

The International Society of Traumatic and Orthopedic Surgery (SICOT) is announcing a "Congress Fellowships" to the October 1972 meeting in Israel. Specifically, the Israeli section of SICOT, in conjunction with that country's Orthopedic Association, is offering 15 travel fellowships to the SICOT Congress which will take place in Israel from October 9 to 13, 1972. This fellowship includes free air travel and seven days, full board, in Israel.

The fellowship is a scientific competition for the best original paper on an orthopedic subject or any basic subject connected with that field of interest. The competition is open to every surgeon or traumatic scientist born in 1929 or later.

For more details write to the SICOT office in Belgium: Société Internationale de Chirurgie, Orthopédique et de Traumatologie, 43, rue des Champs-Elysées, Bruxelles 5, Belgique. Final date for submission of papers is January 31, 1972.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

November

11 **Bergen County Medical Society**

11 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Antibiotics

11 **TB-Respiratory Disease Association of Southern New Jersey**

11 **Ocean County Medical Society**

11 **Middlesex County Medical Society**

11 **American College of Physicians and New Jersey Society of Internal Medicine**
Holiday Inn, Trenton
Annual Meeting

11 **Montclair Community Hospital**
Montclair
Management of Shock

11 and 18 **Academy of Medicine of New Jersey**
Mountainside Hospital
Montclair
Esophageal Disease

11 **Columbus Hospital**
18, 25 Hospital Annex, Newark
Simplified ECG for the family physician

11, 18 **Muhlenberg Hospital**
25 Plainfield
Gastroenterology

12 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Renal Disease

12 **Burlington County Memorial Hospital**
Mount Holly
Acute Abdominal Trauma

12 **Somerset Hospital**
Somerville
Chemotherapy in Neoplasms of the Breast

12 **Essex County Medical Society**
Sandoz Postgraduate Lecture
Carriage Trade, East Orange
Ghetto Medicine

17 **United Hospitals of Newark**
Eye and Ear Infirmary, Newark
Surgery of Lacrimal Apparatus

17 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Renal Failure

18 **Academy of Medicine of New Jersey**
Atlantic City Hospital
Atlantic City
Drug Addiction

18 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Fever of Unknown Origin

19 **Burlington County Memorial Hospital**
Mount Holly
Burns: Current Therapy

19 **Morris County Medical Society**

19 **Gloucester County Medical Society**

19 **Somerset Hospital**
Somerville
Graduate Teaching Program

30 **Cape May County Medical Society**

December

2 **Hudson County Medical Society**

2 and 9 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Uremia

2, 9, 16, 23, 30 **Muhlenberg Hospital**
Plainfield
Gastroenterology

2, 9, 16, 23, 30 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

3 **Somerset Hospital**
Somerville
Non-Surgical Therapy in Malignant Tumors

3 **Burlington County Memorial Hospital**
Mount Holly
Intensive Radiation Therapy

3-4 **Academy of Medicine of New Jersey**
Saint Barnabas Medical Center,
Livingston
Culdoscopy Workshop

8 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Antibiotics

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

8 **TB-Respiratory Disease Association of Southern New Jersey**

8 **Ocean County Medical Society**

8 **Middlesex County Medical Society**

9 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Pulmonary Disease

10 **Burlington County Memorial Hospital**
Mount Holly
Antimicrobial Agents

10 **Somerset Hospital**
Somerset
Chemotherapy of Solid Tumors in Children

10 **Sandoz Postgraduate Lectures**
Sandoz Auditorium, Hanover
Gonorrhea

12 **Academy of Medicine of New Jersey**
Section on Plastic Surgery
St. Barnabas Medical Center
Livingston
Head and Neck Surgery

14 **Academy of Medicine of New Jersey**
Paul Kimball Hospital
Lakewood
Cardiac Arrhythmias

15 **Academy of Medicine of New Jersey**
Englewood Hospital
Englewood
Hepatitis

15 **Academy of Medicine of New Jersey**
Burlington County Memorial Hospital
Mount Holly
Diagnosis and Treatment of Shock

16 **Academy of Medicine of New Jersey**
Bergen Pines Hospital, Paramus
Coronary Cineangiography

16 **Academy of Medicine of New Jersey**
Mount Sinai School of Medicine
New York
Hematology

16 **Academy of Medicine of New Jersey**
Cornell Medical Center, New York
Transplantation

17 **Morris County Medical Society**

17 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar

17 **Somerset Hospital**
Somerville
Immunosuppressive Agents in Malignancy

1971

January

5 **Hudson County Medical Society**

6, 13, 20, 27 **Columbus Hospital**
Hospital Annex
Simplified ECG for the family physician

6, 13, 20, 27 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Cardiology

6, 13, 20, 27 **Muhlenberg Hospital**
Plainfield
Gastroenterology

7 **Burlington County Memorial Hospital**
Mount Holly
Lymphoid-Immune System

10 **Bergen County Medical Society**

10 **Gloucester County Medical Society**

10 **Warren County Medical Society**

10 **TB-Respiratory Disease Association of Southern New Jersey**

10 **Ocean County Medical Society**

10 **Middlesex County Medical Society**

13 **Academy of Medicine of New Jersey**
State Hospital, Trenton
Drug Addiction

14 **Burlington County Memorial Hospital**
Mount Holly
Immunity, Genetics, and Virus Infections

19 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Leukemia and Lymphoma

20 **Academy of Medicine of New Jersey**
VA Hospital, Lyons
Emergency Room Care

21 **Burlington County Memorial Hospital**
Mount Holly
Immune Mechanisms in Lupus Erythematosus and Rheumatoid Variants

28 **Burlington County Memorial Hospital**
Mount Holly
Immunologic Abnormalities in Neurologic Diseases

February

2 **Hudson County Medical Society**

3 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Diagnosis and Treatment of Shock

3 **Muhlenberg Hospital**
Plainfield
Gastroenterology

3 and 10 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Cineangiography

3, 10, 17, 24 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

3, 10, 17, 24 **Muhlenberg Hospital**
Plainfield
Neurology

4 **Burlington County Memorial Hospital**
Mount Holly
Immunology and Neoplastic Diseases

4 **Saint Barnabas Medical Center,** Livingston
Hormonal Cytology

9 **Academy of Medicine of New Jersey** Morristown Memorial Hospital Morristown
Antibiotics

11 **Burlington County Memorial Hospital** Mount Holly
Fibrinolysis and Fibrinolytic Agents

16 **Academy of Medicine of New Jersey** Englewood Hospital, Englewood
Diagnosis and Treatment of Shock

18 **Burlington County Memorial Hospital** Mount Holly
Emotional and Psycho-social Maturation

24 **Academy of Medicine of New Jersey** Albert Einstein Medical Center, Newark
Pediatric Renal Disease

25 **Burlington County Memorial Hospital** Mount Holly
Physiology of Puberty and Psycho-sexual Maturation

March

2 **Hudson County Medical Society**

2 **Academy of Medicine of New Jersey** Section on Dentistry **Academy of Medicine Offices** Bloomfield
Saliva in Reference to Systemic Disease

3, 10, 17, 24, 31 **Muhlenberg Hospital** Plainfield
Neurology

3, 10, 17, 24, **Columbus Hospital** Hospital Annex, Newark
Simplified ECG for the family physician

4 **Academy of Medicine of New Jersey** Warren Hospital, Phillipsburg
Drug Addiction

4 **Burlington County Memorial Hospital** Mount Holly
Management of Infertile Couple

4 **Academy of Medicine of New Jersey** National Institutes of Health Bethesda, Maryland
Clinical Infectious Diseases

4 **Saint Barnabas Medical Center** Livingston
Multiparous Trap

8 **Academy of Medicine of New Jersey** Paul Kimball Hospital Lakewood
Drug Addiction

9 **Bergen County Medical Center**

9 **TB-Respiratory Disease Association of Southern New Jersey**

9 **Middlesex County Medical Society**

10 **Academy of Medicine of New Jersey** Overlook Hospital, Summit
Respiratory Failure

11 **Burlington County Memorial Hospital** Mount Holly
Sexual Problems Seen in Office Practice

16 **Academy of Medicine of New Jersey** Overlook Hospital, Summit
Renal Failure

16 **Academy of Medicine of New Jersey** Burlington County Memorial Hospital Mount Holly
Generation Gap in Medicine

17 **Academy of Medicine of New Jersey** Atlantic City Hospital
Emergency Room Care

17 **Academy of Medicine of New Jersey** Cornell School of Medicine, New York
Cardiac Drugs

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

18 **Burlington County Memorial Hospital** Mount Holly
Biochemical Parameters of Aging

24 **Academy of Medicine of New Jersey** Dental Section Veterans Hospital, East Orange
Symposium on Intact Dentition

24 **Academy of Medicine of New Jersey** Massachusetts General Hospital, Boston
Gastrointestinal Disease

25 **Burlington County Memorial Hospital** Mount Holly
Hyperlipoproteinemias

29 Cape May County Society

31 Academy of Medicine of New Jersey
Cornell Medical Center, New York
Heart Surgery

31 Academy of Medicine of New Jersey
Symposium—Controversy in Medicine

April

1 Burlington County Memorial Hospital
Mount Holly
Pre-diabetic Syndrome

5 Academy of Medicine of New Jersey
Greenville Hospital, Jersey City
Emergency Room Care

6 Hudson County Medical Society

7 and 14 Academy of Medicine of New Jersey
Holy Name Hospital, Teaneck
Uremia

7, 14, 21, 28 Columbus Hospital
Hospital Annex, Newark
Simplified ECG for the family physician

8 Burlington County Memorial Hospital
Mount Holly
Recent Advances in Diabetes Mellitus

8 Saint Barnabas Medical Center
Livingston
Irradiation Therapy

13 Cumberland County Medical Society

13 Bergen County Medical Society

13 Middlesex County Medical Society

14 TB-Respiratory Disease Association of Southern New Jersey

14 Academy of Medicine of New Jersey
Runnells Hospital, Berkeley Heights
Difficult Diabetic Patient

15 Gloucester County Medical Society

15 Morris County Medical Society

15 Burlington County Memorial Hospital
Mount Holly
Management of Exogenous Obesity

20 Warren County Medical Society

20 Academy of Medicine of New Jersey
Englewood Hospital, Englewood
Leukemia and Lymphoma

21 Academy of Medicine of New Jersey
Yale—New Haven Medical Center
New Haven, Connecticut
Endocrinology

21 Academy of Medicine of New Jersey
Saint Michael's Medical Center, Newark
Cardiovascular Workshop

22 Burlington County Memorial Hospital
Mount Holly
Hypercalcemia

29 Burlington County Memorial Hospital
Mount Holly
Interservice Seminar

May

4 Academy of Medicine of New Jersey
Morristown Memorial Hospital
Morristown
Diagnosis and Treatment of Shock

4 Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Drug Addiction

5, 12, 19 Columbus Hospital
Hospital Annex, Newark
Simplified ECG for the family physician

6 Saint Barnabas Medical Center
Livingston
Familia Toxemia

6 Burlington County Memorial Hospital
Mount Holly
Drug Abuse

11 Academy of Medicine of New Jersey
Overlook Hospital, Summit
Diagnosis and Treatment of Hypertension

13 Burlington County Memorial Hospital
Mount Holly
Management of Acute Drug Intoxication

15 to 18 The Medical Society of New Jersey
Haddon Hall, Atlantic City
Annual Meeting

20 Burlington County Memorial Hospital
Mount Holly
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OBITUARIES

Dr. Donald M. Caldwell

On October 5, at the age of 65, a sudden myocardial infarction caused the death of Donald M. Caldwell, M.D., of East Orange. Dr. Caldwell received his M.D. degree in 1933 from the University of Wisconsin. He served the Prudential Insurance Company for several decades and was senior physician there at the time of his retirement in 1955. Dr. Caldwell was a Fellow of the Academy of Medicine and was active in Masonic affairs. During World War II, he was a Major in the AUS.

Dr. George K. DeHart

At the age of 63, George K. DeHart, M.D., died rather suddenly on August 18, 1970. He was a well-known figure in Verona, a member of our Essex County Medical Society, and active in committee work for the Academy of Medicine. Dr. DeHart was a general practitioner and attending internist at Montclair's Community Hospital. He was a 1934 graduate of the Medical School of the University of Rochester.

Dr. Harry R. Epstein

In 1960, at the age of 62, Harry R. Epstein, M.D., decided to retire from his busy practice in Brooklyn and take life easy. He had served in many civic capacities in New York City in addition to carrying the burdens of the old fashioned family doctor. So, Dr. Epstein retired to Mahwah, New Jersey; only he didn't take things easy. He became a country doctor, served the Visiting Nurses' Association, identified himself with the staff of the Valley Hospital in Ridgewood, and served the police, the board of health, and the schools. His useful and busy life came to an end on August 24, 1970, when he died at the age of 72. He had received his M.D. degree at Long Island in 1927, and was a member of our Bergen County Medical Society.

Dr. Thomas M. Heslin

One of Middlesex County's leading ophthalmologists, Thomas M. Heslin, M.D., died on September 6, 1970. Born in 1919, he was only 51 at the time of his death. He earned his M.D. degree at Long Island in 1943. He chose ophthalmology as soon as he was demobilized, and became a board diplomate in that specialty, and, later, chief of ophthalmology at St. Peter's Hospital in New Brunswick. He was a Fellow of the American College of Surgeons, and active in the New Jersey Academy of Opthalmology and Otolaryngology. Dr. Heslin was also an attending in ophthalmologic surgery at the Middlesex General Hospital.

Dr. Charles Margulies

Born in 1909, Charles Margulies, M.D., of Nutley, died on August 15, 1970 at the untimely age of 61. He was a general practitioner with special interest in diabetes and was an active member of the New Jersey Diabetes Association. He was a Bellevue graduate (1933) and was director of the Diabetes Service at St. Mary's Hospital in Passaic. Dr. Margulies was also affiliated with the Clara Maass Hospital in Belleville.

Dr. George D. Trustan

Dr. Trustan used to pride himself on jogging every morning. And on September 14, 1970, after the usual jog, he suddenly died, at the age of 51. In some respects, he was Mr. Medicine for Ocean County. He had been President of the County Medical Society, and since 1968 had been the Ocean County Medical Examiner. Since 1957 he had been interested and active in the Beachwood First Aid Squad and was awarded a special plaque for that activity. He was graduated from the Albany Medical College in 1950, and was on the staff of the Community Hospital in Toms River.

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Saddle Brook, New Jersey 07662

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CLASSIFIED ADVERTISEMENTS

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HAS DRINKING BECOME A PROBLEM?—If alcoholism in any way interferes with your work, health or family relations, you may need our help. The Medical Professional Group of Alcoholics Anonymous meets every Friday in North Central New Jersey. Our main aim is to help the alcoholic physician or dentist achieve and maintain sobriety. Anonymity preserved. Call (201) 242-1515.

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ADDITIONAL PERSONNEL PAGE 766 ←

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BOOK REVIEWS

Homeostatic Regulators (Ciba Foundation). Edited by G. E. W. Wolstenholme and Julie Knight. Baltimore, 1970, Williams and Wilkins. Pp. 327. Illustrated. ($13.75)

Here is a Ciba Foundation Symposium, including 17 papers, each by a different author, presented in January, 1969. The text concentrates on cellular homeostatic regulators. It will be of interest to those engaged in research in the field of homeostasis. Included are such subjects as chalones, histones, enzymes, isoenzymes, interferones, lysosomes, cell surfaces, and so on. Each paper is followed by a general discussion of the subject just as it took place at the symposium. This format is excellent.

The prime question of the symposium is whether the internal environment of a living organism rests on definable entities rather than on a number of interlinked and patterned events with built-in feedback mechanisms. Three conclusions are advanced: (1) molecular entities probably exist which do have some homeostatic functions, especially in special, specific conditions, (2) the integrated action of several factors is probably necessary to maintain cellular equilibrium, and (3) there may exist several related homeostatic systems which are highly selective with respect to the kind of biological level and type of tissue in which they function.

Allan Lazar, M.D.

Psychedelics. Edited by Bernard Aaronson, Ph.D. and Humphry Osmond, M.D. Garden City, New York, 1970, Doubleday. Pp. 512 (Softback $2.45)

It was Dr. Osmond who coined the word *psychedelics*. He and Dr. Aaronson are with the Bureau of Research at the New Jersey Neuropsychiatric Institute. This is a collection of papers, many of them written by the editors, on various aspects of the use of, the pharmacology of, and the psychology of the "mind expanding" or "experience enhancing" drugs. The drugs here covered include peyote, psilocybin, yage, LSD, marijuana, and mescaline. Many authors describe their own experiences with these preparations. The drugs, the editors feel, do indeed expand consciousness, enable the therapist to lead the patient into the deeper recesses of his mind, and permit him to identify with the fantasies of the psychotic. If psychedelics were regularly used within a family "this might have an impact on our society equivalent to that of the machine which, in setting off the industrial revolution, created much of what we now consider our natural life style." The fact that the sale or transportation of many of these drugs is illegal is, the writers suggest, unfair since this legal limitation restricts honest research into psychedelics. If the psychiatrist would himself try these drugs, he would learn about emotional disorders not by "reliance on stale authority, but on fresh observation." Indeed, if "psychiatrists would listen seriously to mad people, they would realize that they are telling us of voyages of the human soul that would make the wanderings of Odysseus seem no more than a Sunday outing." Conventional reality, one of the authors tells us, depends on the reaction of external stimuli within our own imperfect perceptive apparatus, and maybe with psychedelics we could learn of a "deeper reality."

Most of the chapters are well written (in some respects, rather vividly written). While some of it has to be labelled special pleading—or even propaganda—it does present an unusual viewpoint with which all of us should be more familiar.

Henry A. Davidson, M.D.

Current Diagnosis and Treatment, 1970. Henry Brainerd, M.D., Marcus A. Krupp, M.D., Milton J. Chatton, M.D., and Sheldon Margen, M.D., Editors. Los Altos, California, 1970. Lange Medical Publications. Pp. 884. ($11.00)

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The information is up to date. The writing is clear cut, concise, and eminently readable. At $11 the price is right. The paperback binding is sturdy and the print legible to these presbyopic eyes.

This manual is not for the physician interested in doing a research project or in an exhaustive medical analysis. But it would be appropriate for the bookshelf of any intern or practitioner who wishes a handy, easily manageable, quick-reading reference.

Leo Lewin, M.D.

Synopsis of Obstetrics (8th Edition). Charles E. McLennan, M.D. St. Louis, 1970, Mosby. Pp. 498. Illustrations 212. ($9.50)

To reach an eighth edition a book must have a lot going for it. This synopsis has as its objective to provide the undergraduate medical student with a source for an initial survey of obstetrics or a concise summary for pre-examination review. It does not disappoint the reader. There is no easy way to present such a vast amount of material in a limited space and make it enjoyable. The author succeeds in the former but must fail in the latter. It would be a mistake for any medical student to think that this "is all there is" to obstetrics. The hard facts are there but not the life.

The chapters are short, clear and concise. The area on fetal development and physiology is especially clear. I do not agree with the author that interval surgical sterilization is rarely justified. To devote precious space to craniotomy and embryotomy seems a waste. Cranioclasts and basiotribes belong to a different era and are not even available in most hospitals.

Another plea is to be made for lowering the cost of such a text by using a paper-back type edition, with less glossy paper. As a review of obstetrics it is a worthwhile publication.

Gerard F. Hansen, M.D.

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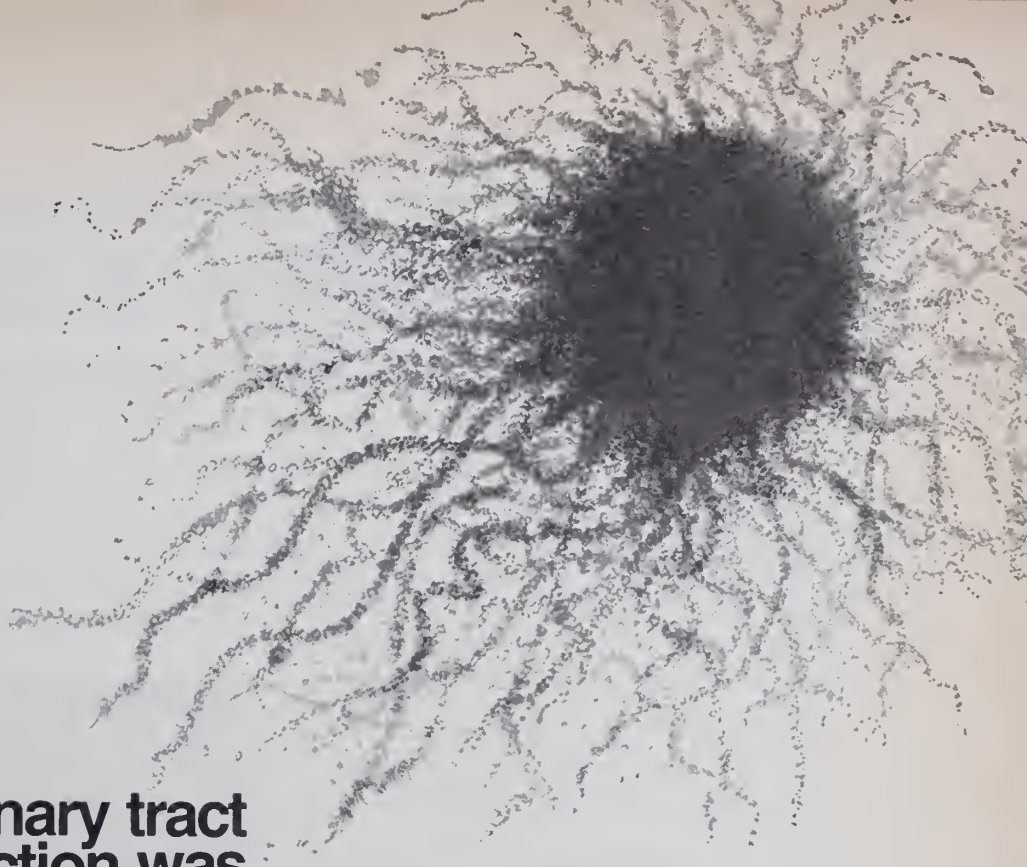
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EDITORIALS

The Concept Of "Normal"

Since nobody is perfect, it is not normal to be perfect. Is a patient normal if the only thing wrong is 20/30 vision in one eye? If his only blemish is a slight case of athlete's foot between two toes? Or if he is 5 pounds overweight?

What is "normal" anyway? Actually there are five possible definitions: (1) Normal is what is culturally acceptable. Heterosexuality is normal; homosexuality is not. Obeying the law is normal under this concept. (2) Normal is the statistical average. By this yardstick, it is normal to drive faster than the speed limit; normal to park in a no-parking area. By this standard, normal weights are higher in the U.S.A. than in China. If it were shown that the average of systolic blood pressure of all 50-year old men was, say, 170, then 170 would be the normal systolic blood pressure for this group. (3) Normal is the ideal. If you do not conform to the height-weight tables then you are not normal. It is not normal to wear eyeglasses or dentures by this concept. (4) Normal is the traditional. A few winters ago, it was not normal for women to wear slacks; a few summers ago it was not normal for them to wear shorts. The norms have changed. (5) Normal is the absence of any finding of disease. An x-ray report that the chest is normal would come under this definition.

Anyone concerned with child rearing will know how plastic the concept of normal is. Is it normal for children to cry, or wet themselves at the age of 18 months? Is it normal for children to be afraid of thunder, or for parents to feed them whenever they are hungry?

The slipperiness of the concept of "normal" makes our work more difficult. Patients always want to know whether their blood pressure or blood counts are "normal." New mothers want to know whether the just-delivered infant is "normal." Health and life insurance companies hesitate to insure people who show abnormalities, though they are not certain how to measure "normal."

We have had to abandon the ideal of "excellence" as the norm, since under the ancient criteria no one would be normal. Shall we ever again return to a state of innocence when padding an expense account is "abnormal?" Shall we ever have many people so radiantly healthy that the most meticulous examination will disclose no carious tooth, no deviation from the weight-height table, no flat feet?

How much daily (or weekly) consumption of alcohol, or tobacco, is normal? Is it normal to drive to the corner store instead of to walk there? Is a pulse of 86 normal? Normal, let's face it, is a myth. There are at least five definitions, and an imaginative observer can dream up a few more. If none can define it, few can achieve it. Certainly it is not absolute. When asked: "Are the findings normal?" we have a right to answer: "For what set of circumstances?"

Special Delivery

Back in Washington they have enacted legislation removing postal operations from direct Government involvement. At the same time there is increasing pressure to involve the Government in the delivery of medical care. If the thought is that direct Governmental operation is undesirable in delivering a letter, one wonders why it becomes desirable for delivery of health care. Part of the trouble may lie in the curious use of the verb, "deliver" for "care of a patient."

Clifford Graves, M.D.,* writing in the *San Diego* (California) *Physician*, suggests that "people are always talking of delivering medical care as if it is something stockpiled in

*Cited in the October 26, 1970 *AMA News*.

Washington and sent out parcel post. A doctor doesn't treat his patients any more. He delivers medical care. Come to think of it, he isn't even the doctor any more. He is the provider of medical care, the vendor, or the medical deliveryman . . . Excuse me while I go to our local health facility to deliver medical care to some of my consumers . . ."

We cling, perhaps foolishly, to the idea that medical care is not really "delivered." You can measure how many cans of beans a packer should be able to pack per hour, or even how many words a minute a secretary should be able to type, but the analogy doesn't hold for taking responsibility for caring for a human being. Perhaps in the brave new world a computer can be programed to tape out a diagnosis if the doctor (or the clerk) pushes the buttons to feed in the symptoms, and maybe even a second computer can disgorge a tape with a treatment regime printed on it. But as of today, if we are "delivering" care, it is a very special delivery indeed.

The Reluctant Muse Of Medical History

A man might be a magnificent spot welder or television repairer without knowing or caring anything about the early history of iron working or the development of the first TV tube. But one of the measures of a learned profession, as distinct from a trade or craft, is an interest in its historical background. And, of course, there *are* some physicians, including several like Morris Saffron in our own state, who have acquired distinction for their grasp on historical trends in medicine and surgery. But by and large, this is a neglected aspect of our professional life. Medical school curricula are already overcrowded with the meat of medicine, so that the educators may feel that there is no space for what they see only as an ornament to the understanding of our work. And it may be, that "medical history" can never be a required course in any medical school, since to present it properly, the teachers would have to probe every specialty in surgery and medicine. Nor can it be said that one would have to know the curious story of the Chamberlin family in order to use the obstetrical forceps properly. The pediatrician can, indeed, perform a fine smallpox inoculation without understanding the role of Lady Mary Montagu in its popularization. So the argument for more emphasis on medical history cannot be based on its practicality. But the fact remains that a grasp of historical development is not only the badge of an educated man, it helps us understand things today if we know how they got that way.

Cicero once wrote: "Not to know what happened before one was born is always to remain a child." The fact that medical history is so complex and written on so variegated a tapestry is hardly any reason for not studying at all. Dr. Fishbein** has cited the suggestion of Dr. F. F. Cartwright of Kings College Hospital (London) that "every medical teacher should combine the past with the present so as to impress his student with the continuing story of his subject." He who teaches pharmacology will certainly find a gold mine of ancient and medieval lore on that subject. The instructor in neurology can show how the mysterious black box that is the skull was slowly made transparent by the studies and researches of 18th and 19th century neuro-anatomists. The changing technics of obstetrics offer some index to the kind of civilization we have. The discovery of the circulation of the blood led off a chain of historical events about the human heart which is even now coming to another milestone with the development of transplantation. It is hard to see why a teacher would start only with the craftsmanship of today without telling his pupils something about the development of that skill. Didacus Stella once said that "dwarfs on the shoulders of giants see more than the giants do." If in this world, each of us seems an intellectual pygmy, indeed, let us at least honor the giants on whose shoulders we stand. Those giants are our intellectual sires.

**In his editorial in the January 16, 1970 *Medical World News*

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Drug Laws And Enforcement Policies

Is Repression The Answer?

Rufus King, LL.B./Washington, D.C.

Our beloved United States has not done anything right with respect to drug addiction and drug abuse since about 1912. Even before that, our history had some pretty seamy spots, when our Yankee ancestors founded some great American fortunes pushing opium addiction on the Chinese, and when we let patent medicine promoters flood the country with dope-laden nostrums that were early required to bear the legend "poison" in other civilized societies.

When Theodore Roosevelt took the lead in calling the Shanghai Conference which led to the Hague Opium Convention of 1912, he was concerned principally with getting exploiters of the traffic out of China, not with pushing our federal government into a prohibition effort at home. When Congress passed the Harrison Act, in 1914, it relied on the tax power, simply imposing a modest tax on opium and coca products and requiring some record-keeping so that commerce in these drugs would be brought out into the open.

The constitutional basis for a federal prohibition effort against drug use has always been shaky. It is hard to think of any activity further removed from areas of legitimate federal concern than what individual citizens ingest, inhale, or inject into their bodies. And no one had the slightest doubt that when we went off on the dizzy attempt to repress liquor drinking, a constitutional amendment was required. That, indeed, was the source of much of the trouble: in a hysterical atmosphere whipped up by war scares, by publicity-seeking politicians, and even significantly by a prominent New York society woman, the modest Harrison Tax Act landed in the same new law enforcement unit which was set up in 1919 to enforce the Volstead Act. Treasury agents had never been involved in much cop-and-robber stuff, and the new Prohibition Unit simply ran amok.

If you think the headlines about teenage deaths from drugs and dope-induced crimes tend toward hyperbole today, you should take a look at the *New York Times* for the years 1919 to 1922. Treasury agents, awash in corruption and initiating all the odious law enforcement practices, like entrapment and the use of informers (which have characterized their efforts ever since), launched an unholy crusade against addicts and anyone who tried to help them. Clinics, set up to minister to persons with addiction problems (who had never dreamed of getting mixed up in criminality) were bullied into closing. Doctors were driven right out of the field by a cynical trick, which induced the Supreme Court to interpret the Harrison Act as preventing a

* Read before the Special Session on Drug Abuse, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1970.

physician from administering or prescribing drugs to an addict to alleviate symptoms of addiction. This opinion was repudiated in the strongest possible language by the Supreme Court two years later—but too late to have much effect on the pattern.

During the middle twenties there were more people serving time in federal penal institutions for drug offenses than for bootlegging—and a not inconsiderable number of the prisoners were doctors and pharmacists.

In 1930, Mr. Anslinger became Commissioner of Narcotics, and for the ensuing three decades he imposed a blackout on all rational contemplation of drug problems. He played with consummate skill on the prejudices of ambitious lawmakers like Hale Boggs and Price Daniel. He scared the American people by connecting the "dope traffic" with everything from Murder, Inc. and the Third International to the Sicilian Mafia (which he virtually invented, and on which he had a complete monopoly until Robert Kennedy and J. Edgar Hoover came up with Joe Valachi and Cosa Nostra).

In 1937, to keep pace with Mr. Hoover's vast success in enlarging and glamorizing the FBI, Anslinger enlarged his domain by bringing marijuana into the opium-coca pattern. During World War II he moved the entire League of Nations apparatus to Washington, and browbeat our allies in their dark hours by threatening that American forces could not liberate places like Singapore and Shanghai unless their former holders agreed to stamp out drugs. Decade after decade he simply blanked out the calm situation in the United Kingdom, where drug addicts were treated by doctors as a medical problem, where illicit traffic was unknown, and where addiction involved a few hundred people in a population ranging around 50 millions.

In 1951, Anslinger pushed Congress into enacting exaggerated penalties with mandatory minimum sentences for drug offenses—thus turning back fifty years of effort among enlightened penologists to get rid of the mandatory feature. By 1956, with the theme that addicts are like bearers of contagious disease, he had congressional committees talking about life quarantine, and he was pushing state legislators into passing civil commitment laws without any backup resources in the way of hospitals, so the end result was simply opening another path by which addicts could be led off to jail.

In 1960 the Food and Drug Administration started a campaign to get into the action in its own right by whipping up hysteria about "dangerous drugs." For example, FDA officials, television script writers, congressional witnesses, congressional committees, and finally the President himself pushed the idea that amphetamines were causing truck accidents. Actually in detailed ICC records covering seven years and 175,000 accidents there were only *thirteen* cases in which drugs might have played a part.

In 1965, the federal government got mixed up in the role of repressing domestically maufactured drugs in the amphetamine, barbiturate, and hallucinogenic categories. Anslinger had always opposed this, and it looked as if at least there was some progress because the policing of dangerous drugs was placed in the Food and Drug Administration, with far more medical and scientific orientation than characterized the headquarters of the T-men down the street.

But in 1968, by Executive Order, the whole package—opiates, coca products, marijuana, amphetamines, barbiturates, and hallucinogens were pulled away from everyone else and put in the most law enforcement - oriented department in Washington: the Department of Justice.

Who now determines what drugs shall be the subject of repressive controls? The Attorney General. Who now tells doctors what the limits of good medical practice are in the prescribing of controlled drugs? The Attorney General. Who dominates education about drug abuse? Who is pushing increasingly repressive legislation down the throats of state

legislators? Who overrides rehabilitative efforts, and has a thumbs-up-thumbs-down voice in the direction of research? Mr. Mitchell.

And are we entering an age of benign enlightenment? Are we regaining our cool about drugs? I do not think so and let me give you a sample. Whatever you may think about the Dole - Nyswander methadone program, or the more widely used minimum methadone maintenance programs, they are providing a very important alternate solution for the problem of true addicts who have up to now had absolutely nowhere to turn except the police on one hand and the vicious peddler on the other. In Baltimore and Washington in the black ghettos some shoestring operations have been organized which, in the case of the Black Man's Liberation Centers in Washington, have contacted thousands of addicts and helped them get out of the hopeless crime-for-money-for-drugs cycle. After harassment by local authorities and the Department of Justice, the D. C. Government —noting an actual decrease in the number of addiction-related street crimes—has now begun to cooperate and provide referrals, services, and funds.

But do you know what the Bureau of Narcotics and Dangerous Drugs is doing? Whipping out a set of "guidelines" which are to be officially published as federal regulations and which will reportedly impose impossible restrictions and conditions on these private programs. And worse, do you know what FDA is supposed to be doing in response to Justice prodding? FDA is getting ready to put out a cynical ruling that the use of methadone in treating the symptoms of addiction is a "new" use of the drug, and will require an IND, supported by animal tests, research proposals, and restricted experimental administration.

We are now on the threshold of excesses that will make our past mistakes in the drug field look mild indeed. Drug abuse is becoming a battleground of protest and rebellion on the one hand, and heavy-handed repression on the other. The Pandora's box of new substances capable of abuse is only just opening. The new federal bureau is still in the process of organizing, recruiting, and training its small army of agents, in preparation for what appears a small domestic war on everyone connected with the nonmedical use of drugs. And calm appeals to use a little common sense are simply not being heard very loudly from any quarter.

So if everything seems to be wrong—what's right? In fairness, having taken all these unqualified swings at the situation I should try to set forth what I believe, so anyone who wishes to may swing back at me.

1. No one can blink at the social and health problems facing our society from the abuse of vegetable and chemical substances. The answer does *not* lie in removing all curbs, and I do not advocate unrestricted "legalization," even of marijuana.

2. The worst aggravation would be unrestricted *commercial promotion and exploitation* which harms us so much in the cases of alcohol and tobacco, and which we are actually approaching with respect to some of the peripheral drug substances that are now touted and distributed without restriction. The Federal tax power, as initially contemplated in the Harrison Act (and as it applies to beverage alcohol) should be continued—aiming at a balance between enough tax burden to cut back profits on the one hand and such high rates that large black market activities might be stimulated, on the other.

3. Taxation is the *only* area in which the federal government should stay in the picture (plus, of course, *legitimate* drug regulation as to purity, labeling, and so on.) This will not be achieved at once, but ideally we will someday get Congress to turn its back on the lure of wowing them in the hustings with speeches about how Uncle Sam is saving our children from dope.

4. The intentionally fostered fuzziness about different categories of drugs must be cleared up: opiates and barbiturates are truly addicting and ought properly to be grouped with

alcohol; potent stimulants (amphetamines and cocaine) and powerful hallucinogens (LSD and hashish) should be grouped together for control purposes; and borderline intoxicants like marijuana should be clearly differentiated and downgraded.

5. Talking now about real addicts, who depend on their drug of addiction something as the diabetic depends on insulin, since the myth of the dangerous "dope fiend" has been totally dispelled, and persons incapable of being withdrawn are really only being protected from themselves by our present laws, I think we should go pretty far in providing some kind of liberal drug regime for them. All the police efforts, and addiction-related crime, and tramping on our civil liberties, and periodic hysteria is simply not worth it to save a relatively small handful of incurable wretches from themselves—even if such efforts had any likelihood of accomplishing such salvation, which they do not.

6. At the other end of the scale, under no circumstances, with any drug, should mere *possession* be made a criminal offense. After all, if one of our ladies buys a can of bad tuna fish or some adulterated mouthwash, nobody prosecutes her. The appropriate authorities rightly start going back up the line to find out where the substance came from, and to try to deal with it at its source. The real reason why law enforcement people are so big on possession as a crime is that it enables them to intimidate and abuse drug users so as to turn them into informers and entrappers.

7. Experiments such as the methadone maintenance programs ought to be encouraged instead of being harassed and suppressed. Every way in which people from science and the healing arts, and officials from the Public Health sector, can push into the field to the exclusion of heavy-handed law enforcement is to the good. Ultimately, the police function will hopefully be reduced to the minimal role of supporting and enforcing medical control of serious drug problems, as is the case in England.

8. Fifty years should have been long enough for us to realize that we are not going to have any appreciable effect on our unique drug problems in this country from trying to bribe and bully the rest of the world into playing our game by imposing domestic controls, limiting production, or curbing exports. We should simply write off such efforts and forget them.

9. Education about drugs has its proper place, but it is not much of a place. For half a century school children have been shown how beverage alcohol will cook eggs, and warned of the perils of drink. And similarly scaring eighth grade assemblies about drug subcultures is a sheer waste of time. Vastly more important is concentrated efforts to make contact where the problems are: guidance and information in depth, preferably from a fellow in a white coat, for individuals, families, and specially affected groups where drugs or the danger of drug - abuse patterns are present.

So there it is: minimize Federal participation, classify drugs realistically and provide relief liberally for people who really have an addiction problem and cannot get away from it; tax the traffic in other drugs in such a way as to discourage it and to keep profiteers out of it; wipe out all possession offenses; get out of the international picture altogether; and go very slowly with shotgun-type education programs.

Woodward Building

Can vasospastic crises lead to organic vascular disease? Here's a case which suggests that it can.

Malignant Hypertension Following Pregnancy Toxemia

Sylvan E. Moolten, M.D./New Brunswick

A gap exists between fact and speculation regarding the basis of pregnancy toxemia and its significance for the future well-being of the patient. According to one view toxemia of pregnancy lays the groundwork for subsequent development of hypertension and disease of the blood vessels and kidneys. According to others, pregnancy merely uncovers the *tendency* to vascular and renal disease, already present in latent form, just as it may bring to light latent diabetes. There is, today, no consensus regarding the pathogenesis of pregnancy toxemia. The characteristic lesion in the renal glomeruli ("glomerular capillary endotheliosis") may be merely a result of vasospastic constriction of renal arteries and arterioles. The role of hormonal factors, e.g. angiotensin and aldosterone, has been sharply questioned[1] because of the observation that the pre-eclamptic patient has in fact a much *lower* production of angiotensin and aldosterone than the normal pregnant woman.

The etiologic background for toxemia depends to a considerable degree on external factors including deteriorated economic and social conditions and inadequate prenatal care. The striking reduction in the incidence of this disorder in recent years may, therefore, be attributed in large measure to improved economic conditions and better prenatal care. Even the higher incidence of toxemia in certain families has been correlated with living habits and external circumstances rather than genetic factors.

Perhaps the only factor which occurs consistently in the etiologic background is the high incidence of emotional disorders, marital distress, and similar conditions in patients with pre-eclampsia. The emotional factor may account, therefore, for the higher incidence of toxemia in primigravidas, especially adolescents. The progression of hypertensive toxemia of pregnancy into permanent hypertension in an emotionally labile woman is illustrated in the following case:

A 24 year old housewife suffered from severe hypertensive toxemia in each of her three pregnancies. The last episode occurred three years previously at a time when she was 5½ months pregnant. Toxemia began abruptly in the form of sudden transient blindness in one eye associated with severe hypertension. Blood pressure shot up to 300/150, although just a short while previously her blood pressure and urinalysis had been found normal. She had hemorrhages and exudates in both fundi. The amblyopic eye later recovered most of its vision. The pregnancy terminated in miscarriage.

Subsequently the patient continued to have persistent hypertension and frequent attacks of severe headache and vomiting. She was highly volatile emotionally and somewhat irresponsible. She refused medical care and insisted on treating herself with vitamins.

Shortly before admission to the hospital she became acutely ill and coughed up pinkish frothy material. On admission she was comatose, and blood pressure was 230/100. In the emergency room, she went into cardiorespiratory arrest. Resuscitation restored heart action at a rapid rate. Electrocardiogram revealed atrial tachycardia with 2 to 1 block. The blood pressure dropped rapidly, but with the use of vasopressor drugs could be maintained for several hours at a level of 85/70. Urinalysis revealed specific gravity 1.009, protein 3 plus, sugar 0, acetone 0. Urinary sediment contained 1, 2, or 3 granular casts and 10 to 20 pus cells per high power field. Blood urea nitrogen was 15 mg per cent. Hemoglobin was 14.5 Grams per cent, hematocrit 44.5, white blood cells 13,600, segmented neutrophiles 77, band forms 7. Serum electrolytes were within normal range. Other laboratory findings were not significant. Many coarse rhonchi were heard in both lungs. The patient died the morning after admission.

At autopsy, the lungs were heavy with congestion and edema. A small effusion of watery fluid was present in each pleural cavity. Massive accumulations

of leukocytes and edema fluid filled the alveolar spaces and small bronchi.

The heart was greatly hypertrophied and weighed 470 grams. The inner surface of a large portion of the left ventricle, including its entire outflow tract, was massively hemorrhagic. The subendocardial layer of myocardium was acutely necrotic and infiltrated with hemorrhage. Minor interstitial inflammation was present in other sections of the ventricle. The coronary arteries were widely patent.

The kidneys were normal in size and contour and weighed together 296 grams. They appeared somewhat swollen. Their surface was stippled with tiny pinpoint areas of intense congestion and hemorrhage. On section, the corticomedullary demarcation was somewhat blurred by congestion and edema. Microscopically the glomeruli were for the most part well preserved. The small and medium-sized arteries exhibited striking medial hypertrophy and varying degrees of intimal fibrous thickening which in some of the small arteries had produced almost complete obliteration of the lumen. The arterioles, including the afferent arterioles of the glomeruli, were much contracted and in many instances exhibited fibrinoid necrosis and obliteration. Similar changes involved individual loops of the glomeruli. Scattered small foci of chronic inflammation were present in the cortex. Permission to examine the brain was not granted.

Anatomic Diagnoses

(1) Malignant hypertension clinically subsequent to recurrent toxemia of pregnancy; (2) Malignant nephrosclerosis; (3) Mild chronic pyelonephritis; (4) Pronounced hypertrophy of left ventricle with extensive subendocardial hemorrhage secondary to subendocardial necrosis; (5) Minimal acute interstitial myocarditis; (6) Confluent bilateral bronchopneumonia.

The findings at autopsy in this case are explained best as the result of extreme arterial hypertension of probable vasospastic origin. Its most striking feature was the pronounced hypertrophy of the arterial smooth muscle in various organs, especially the kidneys, and the presence of secondary necrotic changes in renal arterioles and glomeruli consistent with the picture of malignant nephrosclerosis. However, the limited extent of the necrotic change suggests that hypertension had not been continuous but had probably occurred in varying severity, at times in extreme degree, i.e. vasospastic hypertension. This is further indicated by the history of sudden onset of transient blindness in one eye, such as might be caused by intense spasm of a central retinal artery. The striking degree of subendocardial hemorrhage in the left ventricle can be explained similarly as the result of vasospastic ischemic necrosis of the subendocardial layer of the ventricle with secondary hemorrhage.

Vasospastic crises characteristic of pre-eclamptic and eclamptic toxemia may, in fact, constitute the underlying basis for many of the clinical and anatomic changes seen in the acute stage. Despite the apparent paradox of lowered formation of angiotensin and lowered output of aldosterone in toxemic pregnancies compared with normal pregnancies, such patients are unusually sensitive to angiotensin and other vasopressor agents. One may easily surmise that in the case under discussion the vasomotor hyperreactivity of pregnancy toxemia, aggravated by the patient's mental perturbation and heightened emotionality, created a background for intense and prolonged vasospasm which in turn induced reactive fibrosis of the intima of many arteries, particularly in the kidney. This set the stage for progressive restriction of renal blood flow which culminated eventually in malignant nephrosclerosis.

It is highly probable that the findings in this case constitute an extreme example of what may be a commonplace sequel also in many cases of milder pregnancy toxemia. For example in a carefully studied well controlled series Epstein[2] observed that hypertension occurred late in the follow-up period of women who suffered from toxemic pregnancy compared with normal women. As the follow-up period increased to 15 or 20 years after toxemia the incidence of blood pressure increased to 40 per cent. The liability to late hypertension also seemed to increase with the duration of hypertension and proteinuria occurring with pregnancy. There was no difference in the familial incidence of hypertension in the toxemic and control groups. Accordingly his data are consistent with the view that toxemia itself predisposes to the development of late hypertension.

In the present case the anatomic basis for late hypertension lay in the development of in-

timal fibrous thickening of renal arteries provoked by toxemic vascular spasm. Once such fibrosis has been laid down it becomes in turn the basis for slow or rapid development of renovascular hypertension, increasing in severity with length of life. Its rapid development in the present case probably reflects the unusual severity of intimal fibrosis, hence the rapid progression into malignant nephrosclerosis.

Summary

In a 24 year old woman pregnancy toxemia occurred in each of three successive pregnancies and culminated in persistent and eventual malignant hypertension causing death three years after the third pregnancy. Autopsy revealed a probable relation of vasospastic crises to the development of organic renal vascular disease.

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180 Somerset Street

Testing for Hepatitis Carriers

The American Association of Blood Banks (on July 14, 1970) approved a statement on tests identifying viral hepatitis carriers. Although testing for Australia antigen as a donor screening test continues to show exciting promise, the same problems which were described in the National Research Council statement (released January 1970) continue to exist. Therefore, the Association maintains that such testing must continue to be regarded as experimental.

The National Research Council's "Statement on Laboratory Screening Tests for Identifying Carriers of Viral Hepatitis in Blood Banking and Transfusion Services" was published in the February 1970 issue of *Transfusion,* official journal of the AABB. It noted, in part, ". . . it is clear that the sensitivity and specificity of the test for Australia antigen vary among laboratories, and there is no agreement on the establishment of a uniform test or tests. Such agreement would be essential before any test could be brought into general use."

It is still necessary that a standard reagent of controlled potency be developed. This must be approved by the Division of Biologic Standards, and must be available in adequate supply. The Association encourages those blood banks which are able to do such testing and collection of data to hasten the development of standard tests which will be suitable for general use. But the day of routine testing has not yet arrived. Most blood banks are now incapable of such research efforts, which demand additional facilities, funding, technical personnel, a constant source of serum, and the capability of producing consistently potent serum for tests. The extent to which such tests are performed will depend both upon the resources of the blood bank and the goals of the project.

This screening test, at present, will detect only a fraction of all hepatitis carriers. Many blood banks today are unable to enter into arrangements routinely to provide blood which has been tested, with negative results, even though the blood bank's particular research effort involves large scale testing.

The full statement may be obtained from the Association of Blood Banks, 30 North Michigan Avenue, Room 1322, Chicago 60602.

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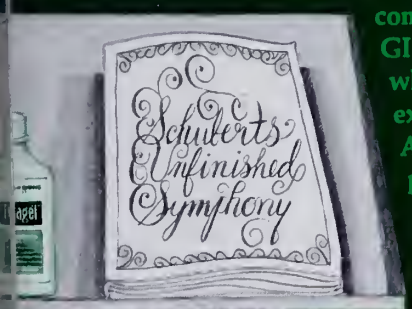
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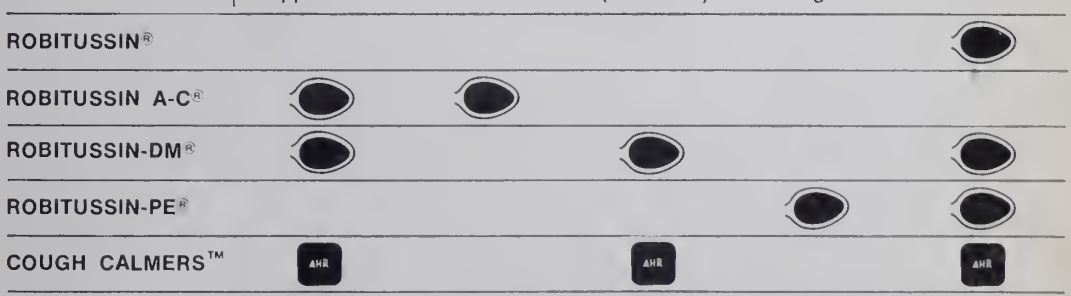
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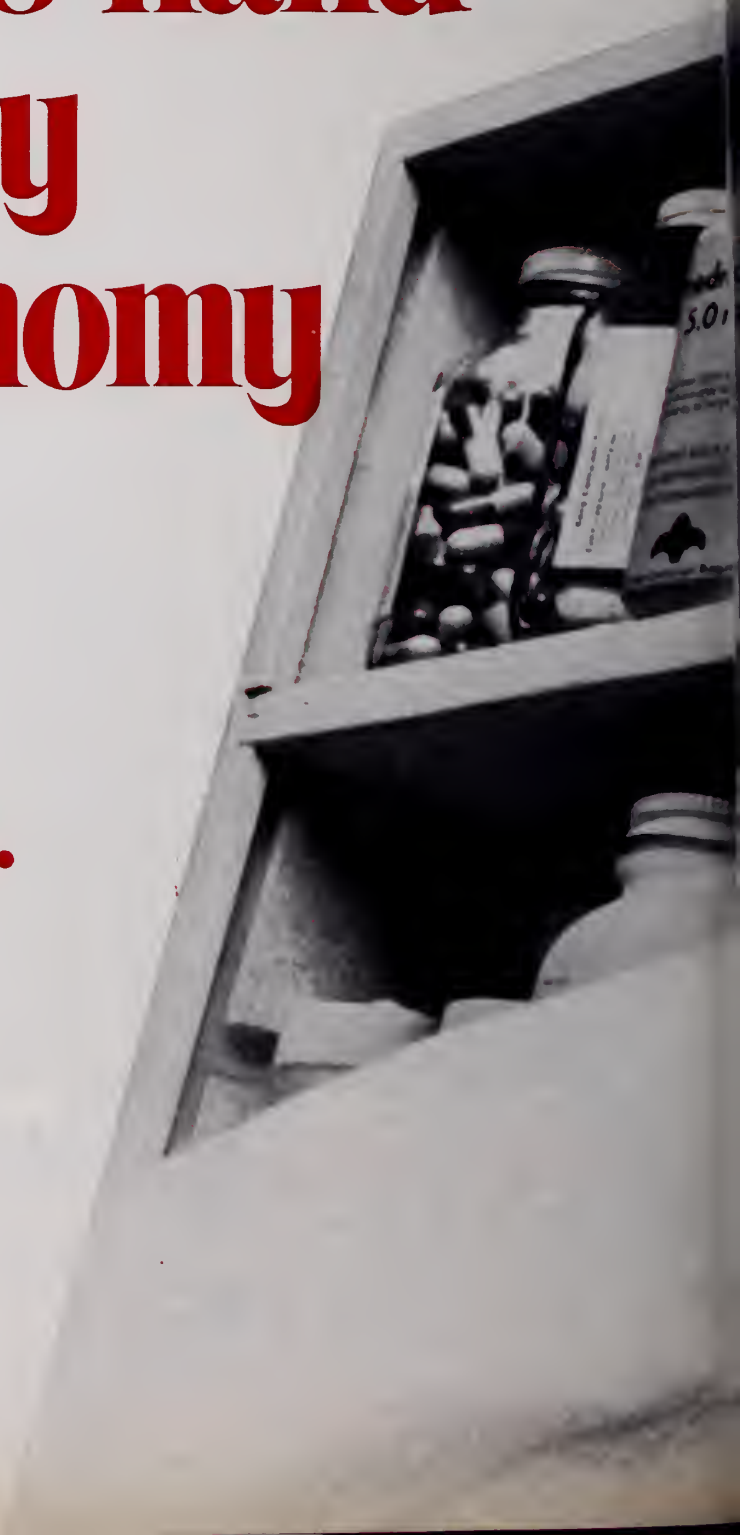
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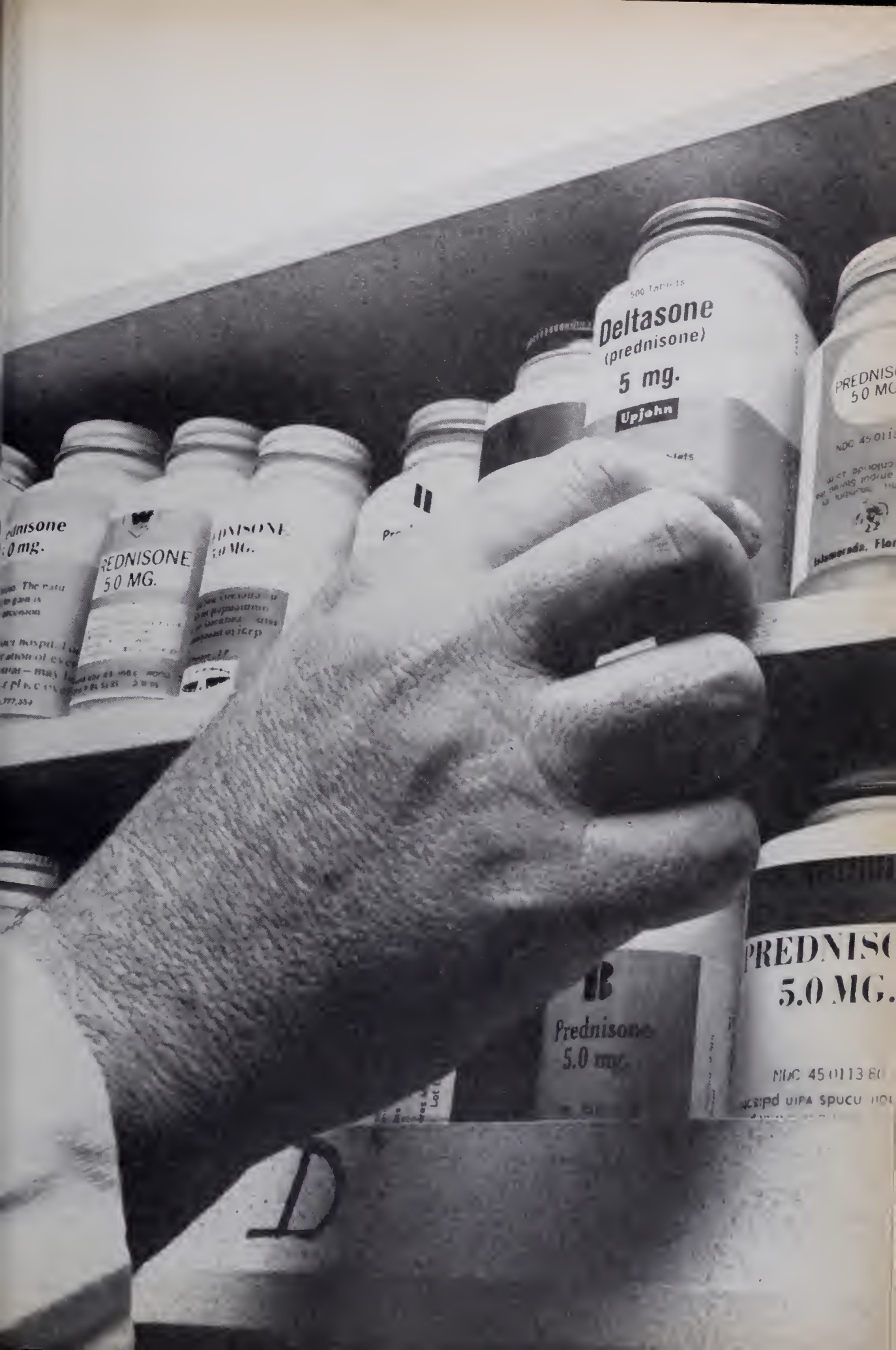
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Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angiitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

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Early treatment of popliteal aneurysm may save the extremity.

Aneurysms Of The Popliteal Artery*

Joseph Alpert, M.D., et al./Newark

The asymptomatic popliteal aneurysm tends to thrombose and produce gangrene of the leg. Gilford and associates[1] found that only 24 per cent of asymptomatic and untreated aneurysms followed for more than five years remained free of complications, and that 50 per cent eventually required amputation. Linton[2] described 15 hospitalized patients with 22 untreated aneurysms who had a 77 per cent limb-loss. Similar findings were recorded by Friesen and co-workers.[3]

Despite repeated admonitions, the potential hazard of this condition is often disregarded. Seldom is the vascular surgeon requested to evaluate the asymptomatic aneurysm. Indeed, referral of the patient with a complicated aneurysm is too often delayed to a point where limb salvation is jeopardized. A review of our experience with popliteal aneurysms at the Newark Beth Israel Medical Center conceivably will call attention once again to their dangers and reaffirm the importance of early diagnosis and surgical therapy.

Clinical Material and Results

The records of 25 patients with 40 popliteal aneurysms treated from 1962 through 1969 were available for analysis. With two exceptions, all suffered recent acute and limb-threatening occlusions of their aneurysms. Formerly, they had been asymptomatic and unaware of any mass behind the knee. Twenty-four of the 25 were males. The mean age at the time of diagnosis was 68, with a range of 45 to 83 years. Diabetes was found in only two patients. Whether a patient was right or left handed had no bearing on the location of his aneurysm. As in other reported series,[4] hypertension, myocardial infarction, congestive failure, or evidence of diffuse cardiovascular disease were present in more than half the patients. The etiology of the aneurysm was arteriosclerosis in every instance.

The initial complaint of 15 of the 25 patients was sudden pain in the leg or foot. (Table I).

TABLE I

Initial Symptoms in 25 Patients With Popliteal Aneurysms

15	Acute claudication or pain	60%
4	Numbness and coldness	16%
3	Gangrene	12%
1	Leg edema	4%
2	Asymptomatic	8%
25		100%

The leg pain was localized to the popliteal fossa or occurred as acute intermittent claudication. Four mentioned numbness and coldness of the foot or toes. Three had already noted frank gangrene. Extensive edema of the limb was observed by another patient, whose admitting diagnosis was thrombophlebitis. Figure 1 shows the time lapse between the onset of symptoms and admission. The shortest interval was one hour and the longest 21 days, with an average of eleven days. The patient with the one hour history was presumed to have had an acute embolic occlusion in view of the rapidity of his symptoms and

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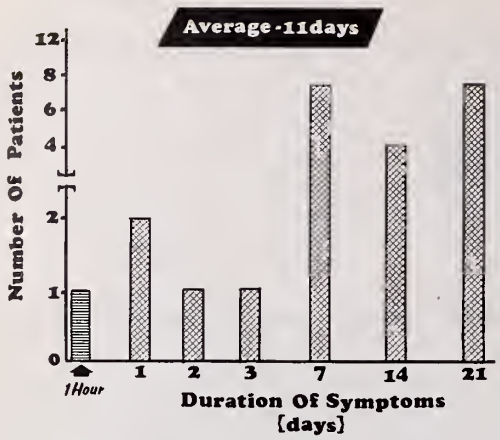


Figure 1—Graph depicting interval between onset of symptoms and hospital admission in 23 patients with complicated popliteal aneurysms.

the absence of a palpable popliteal mass. On examination, 22 extremities had varying degrees of ischemia of which 19 were pregangrenous and 3 gangrenous. The one edematous limb was not ischemic. Twenty patients (including two who were asymptomatic) had a palpable mass on the side in question when first examined and 17 of these were nonpulsatile. In only two instances had the mass been identified by the referring physician prior to hospital entry. In two of the five patients without palpable masses, an aneurysm was suspected when a pulsating mass was discovered in the contra-lateral popliteal fossa and subsequent angiography indirectly suggested the diagnosis. Surgical exploration revealed unsuspected aneurysm in three patients.

Fifteen of the 25 patients (60 per cent) had bilateral aneurysms. Those found on the asymptomatic side were pulsatile with one exception and permitted easy clinical recognition. Twenty-one patients had preoperative bilateral femoral angiography and postoperative angiograms were obtained in 15 patients.

Relief of symptoms and limb preservation constituted the primary indication for surgery although two patients had prophylactic resections of asymptomatic unilateral aneurysms and two others had later resection of the contra-lateral asymptomatic aneurysms. Arterial continuity was restored in six patients by direct end-to-end anastomosis (Table II).

TABLE II

Treatment of 40 Popliteal Aneurysms in 25 Patients

Operation		
6	Aneurysmectomy with direct anastomosis ..	22%
14	Aneurysmectomy with interposed vein graft	52%
3	Exclusion with vein bypass	11%
4	Sympathectomy only	15%
27		100%
Other		
6	Awaiting surgery	
4	Not candidate	
1	Died	
2	Lost to follow-up	
13		

Early anastomotic disruption in one patient necessitated immediate re-exploration and the insertion of a vein autograft. End-to-end repair was attempted, if the proximal and distal ends could be approximated without tension. Primary vascular restoration by interposing a vein graft was done 14 times. Two early vein graft occlusions necessitated secondary revascularization with a Dacron® femoropopliteal bypass graft, both of which occluded. A femoropopliteal autogenous vein bypass graft was inserted in three patients to restore circulation after proximal and distal ligation of the unexcised aneurysm. Lumbar sympathectomy was the sole procedure in four patients because preoperative angiography demonstrated no suitable distal vessel patency to allow direct revascularization.

Seven patients (28 per cent) required a major leg amputation. Three of these patients had advanced gangrenous changes when first seen and the remaining four had impending gangrene. In these four, operation failed as a result of organized and extensive propagated thrombus.

Eighteen limbs were revascularized successfully with restoration of limb function. Compartmental ischemia with sepsis, however, did occur in one patient and resulted in a permanent foot drop. This patient's symptoms had been present for only one hour prior to surgery, illustrating the rapidity with which thrombus may form and propagate to cause

irreparable muscle and nerve damage. Minor toe amputations were necessary in three additional patients.

Comment

A 28 per cent limb loss following surgery for popliteal aneurysms is both discouraging and unacceptable and suggests an indictment of current surgical treatment. Yet the amputation rate is in accord with the experiences of others.[5, 6] Indeed, limb mortality increases with the delay in diagnosis and treatment of symptom-producing thrombosis. When one considers that the average delay from the onset of symptoms to surgical revascularization was 11 days and that 20 patients had a palpable mass when admitted to the hospital, it becomes evident that the popliteal fossa is a region that frequently escapes routine examination. In fact, 60 per cent of the patients had a pulsating mass in the contra-lateral asymptomatic side which was overlooked. This further indicates that physicians are still remiss in examining the poplitical fossa of patients with symptoms usually attributed to arteriosclerosis obliterans.

In popliteal aneurysms, the need for surgery was emphasized by Gifford.[1] Sixty-nine patients with 100 aneurysms were followed for an average of 50 months. Of 68 aneurysms managed by non-operative means, 23 (33 per cent) caused 121 complications, 11 of which terminated in leg amputation. Thirty-five patients were asymptomatic and only three were aware of their aneurysms prior to their examination. Gifford[1] also noted that 24 aneurysms had undergone spontaneous thrombosis, yet amputation was required in 8 instances and the remaining 16 patients experienced residual intermittent claudication. The asymptomatic aneurysm which spontaneously thromboses does not offer any degree of safety against limb loss. Rupture is said[8] to occur frequently,[9] but it was not encountered in this series.

Asymptomatic aneurysms of the popliteal artery should be treated prophylactically. Why, then, do so many reports contain a significant number of unoperated aneurysms? Perhaps an answer can be obtained by analyzing the 15 patients in the present series who had contra-lateral asymptomatic aneurysms. Two have already had aneurysmectomies and six others are awaiting surgery. Bilateral simultaneous operations have not been attempted since the morbidity in the elderly patient who already has diffuse and advanced cardiovascular disease would be prohibitive. The remaining seven patients were unsuitable candidates for further surgery due to senility (2 patients), recent recurrent myocardial infarcts (2 patients), one death, and one loss to follow-up (2 patients). Thus, extenuating circumstances play an important role in the decision for elective resection despite the surgeon's best intentions.

Angiography is an important aid in diagnosis and therapy. If a suspected thrombosed aneurysm is not palpable, angiography indirectly may corroborate the diagnosis. Inference can be drawn from a concave or convex cut-off of the proximal artery, scant collateral circulation with narrowing of the distal and ectasia of the proximal arterial lumen, segmental occlusion of the popliteal artery with or without propagated thrombus, and "seepage" of contrast media between the proximal thrombus and arterial wall.[10] An arteriogram will also reveal the status of the proximal and distal arteries which assists in planning the restorative surgical procedure.

The operation most frequently utilized in this series was aneurysmectomy with restoration of arterial continuity by direct arterial anastomosis or the interposition of a saphenous vein autograft. Local surgical findings dictated the most favorable method. Prosthetic grafts were required in only two patients due to the absence of an adequate saphenous vein. Concomitant lumbar sympathectomy was *not* done routinely. Aneurysm exclusion without resection and saphenous vein bypass deserves more consideration.[11] since division of the medial tendons and injury to the popliteal vein are avoided, thereby diminishing postoperative morbidity. No com-

plications have been noted from leaving the aneurysm behind.

Summary

Twenty-five patients with 40 popliteal aneurysms were treated at the Newark Beth Israel Medical Center during an 8 year period. Aneurysm complications had developed in 23 patients requiring hospitalization and surgery. A total of 4 asymptomatic aneurysms were also resected. The most frequent procedure was aneurysmectomy and vein autograft replacement. Leg amputation was required in 7 patients (28 per cent). This analysis reaffirms that popliteal aneurysms are prone to thrombosis and limb-loss unless diagnosed and treated early. Consideration for elective excision should be accorded the asymptomatic popliteal aneurysm.

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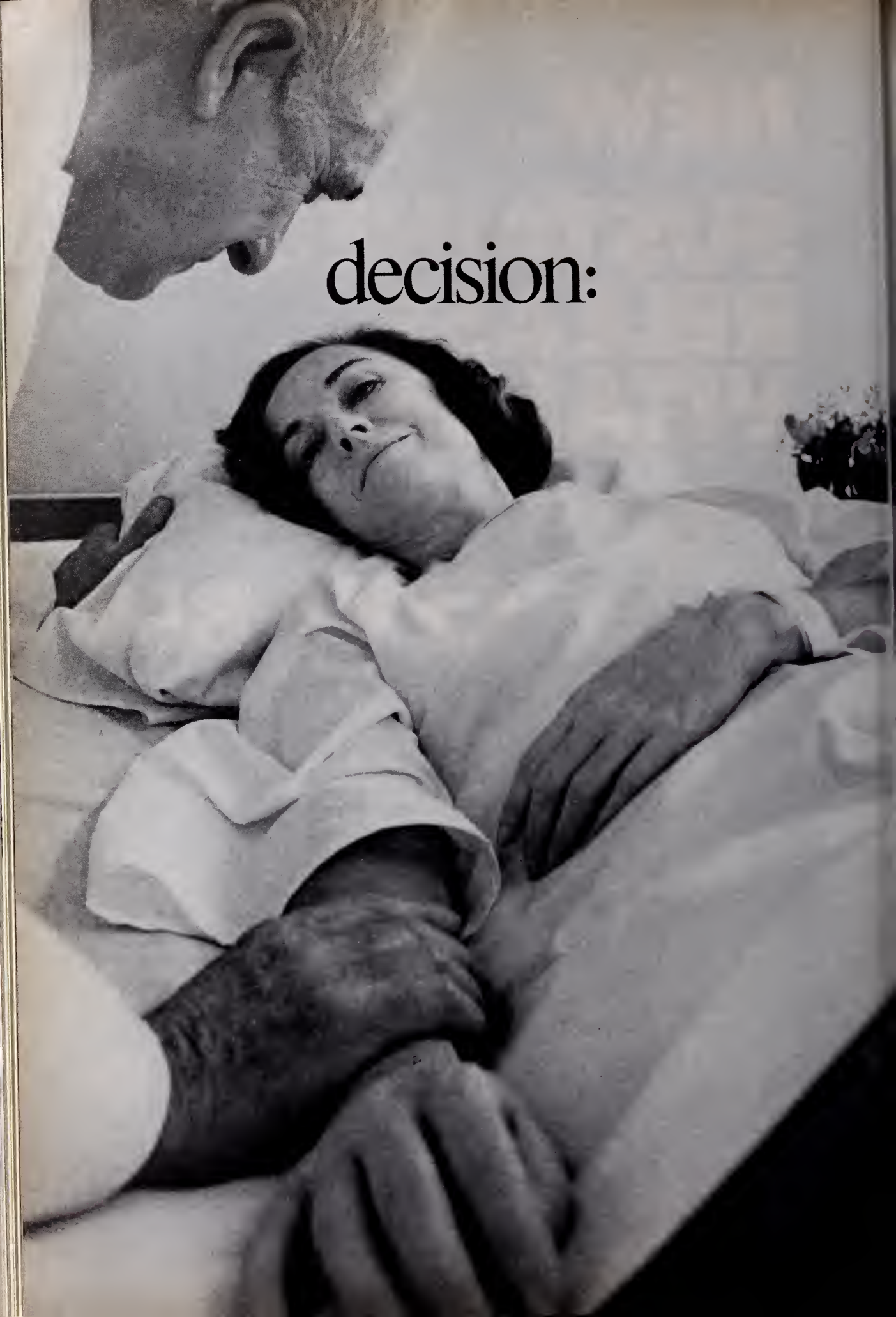
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1. Demonstrate causative organism's sensitivity to the drug.
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1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
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6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

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Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

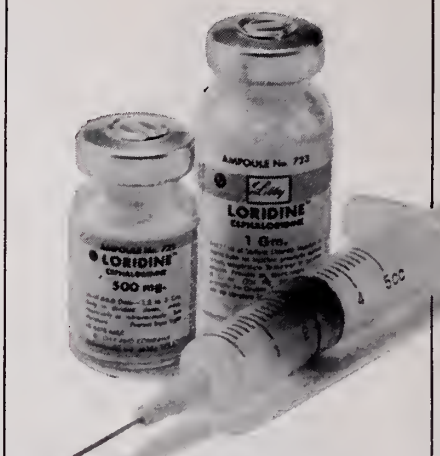
Because of nepbrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function sbould be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in tbe spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If tbey occur, take proper therapeutic measures.

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Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

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Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting bave occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

Additional information available upon request.

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Even in New Jersey we can see nematode infestations. If this leads to an ulcerative colitis, don't prescribe corticosteroids until you have checked for, and treated, strongyloid larvae.

Strongyloidiasis Associated With Ulcerative Colitis*

Melvin Rubenstein, M.D./Westfield

Strongyloides is a parasitic worm of the nematode class. Infestation with this parasite is strongyloidiasis. Generally considered to be a problem in tropical medicine, it is now coming to the attention of physicians in temperate regions. Increasing world travel and migration necessitate an awareness by community physicians of the unusual as well as the common manifestations of this disease. Here is a case report of severe strongyloidiasis with the rarely reported associated radiographic picture of ulcerative colitis. In addition, the infection was unusually resistant to thiabendazole.

A 29 year old female, a native of Jamaica in the Caribbean, was admitted to Overlook Hospital, Summit, New Jersey, complaining of rectal bleeding. Tetracycline had been prescribed following a tooth extraction three days previously. Diarrhea, fecal urgency, and finally bright red rectal bleeding were subsequently noted. In addition, she complained of pallor, marked fatigability, palpitations, and breathlessness. This was in 1968. But in 1962, 1964, and 1966, she had been hospitalized in Jamaica for similar complaints. On each occasion she had been told of marked anemia and strongyloides infestation. Blood transfusions and unknown antihelminthic drugs were given, but strongyloides larvae were never completely eradicated from the stool. There was no history suggestive of malabsorption. Between hospitalizations, the patient generally had one formed bowel movement daily.

She was a pale, dyspneic woman with a pulse of 120, blood pressure 140/65 and respirations of 32. Additional positive findings included a hyperactive precordium, cardiomegaly and a systolic ejection sound at the left sternal border. The abdomen was obese, but otherwise, unremarkable.

Laboratory data disclosed a hypochromic, microcytic anemia with a hemoglobin of 4.7 Grams and hematocrit of 19 per cent. Leucocytes totaled 9,900 with a 6 per cent eosinophilia. Serum iron was 14 with a TIBC of 540. D-xylose excretion, serum carotene, and prothrombin time were normal. Innumerable strongyloides larvae were noted on three successive stool examinations. No occult or gross blood was present at the time of admission. The rectal mucosa was erythematous and granular. Biopsy revealed minimal acute and chronic inflammation but no eosinophilia, granulomata, or stronglyloides larvae.

Barium enema x-ray was striking in that there was total loss of colonic haustral markings as well as shallow ulcerations along the entire length of the colon. (see illustration) This picture was consistent with ulcerative colitis. Upper gastrointestinal and small bowel series were unremarkable.



Barium enema x-ray revealing loss of haustral markings, and multiple superficial ulcerations. There is no foreshortening of the colon. The picture suggests ulcerative colitis.

*This work is from the Overlook Hospital in Summit, New Jersey.

Transfusion of three units of whole blood resulted in marked symptomatic improvement. Subsequently, the patient was treated with 3 Grams of thiobendazole† on two successive days and her stools became negative for strongyloides larvae. When seen again two months following hospital discharge, stools were again positive and at this time treatment with 3 Grams of thiobendazole on five successive days was undertaken. One month later, the stooi examination was negative but study after three months had elapsed revealed stools positive for strongyloides larvae. The patient was again treated with five daily doses of 3 Grams of thiobendazole and stools again became negative. Strongyloides larvae were again noted two months later, however, and have continued to be intermittantly present despite repeated courses of thiobendazole which have been increased to 3 Grams per day for five days successively.

The biology of strongyloides can involve two possible life cycles.[1] In the direct cycle, ova deposited in the upper small intestine metamorphose to rhabditiform larvae which are then passed in the stool. As a free living form, these then develop into infective filariform larvae which may penetrate a potential host's skin and find their way to the duodenum by way of the pulmonary circulation and tracheobronchial tree. Unlike other nematodes, however, autoinfection can occur in strongyloides infestation if the filariform larvae develop within the host. These larvae can presumably reinvade the host at any level of the gastrointestinal tract or through the perianal skin.

Stemmermann[2] has postulated that autoinfection through the colonic wall is responsible for the rarely observed chronic colitis that may be associated with strongyloidiasis. He has described two cases with changes of chronic granulomatous colitis secondary to invasion by filariform larvae. Sporadically other cases have been noted in the literature.[3]

Our patient can be considered by radiologic and proctoscopic criteria to have chronic ulcerative colitis. Rectal biopsy did not disclose the etiology, but it is reasonable to postulate that many years of heavy infestation with S. stercoralis have resulted in a chronic granulomatous colitis secondary to reinvasion by filariform larvae. The only way that this could be definitely resolved would be histologically to examine the entire colon; an impossibility in this case.

Strongyloidiasis now represents a helminthic infection which *can* be effectively treated with thiobendazole† with a minimum of side effects. Successful treatment[4] should theoretically arrest the progress of the associated colitis.[5] Unfortunately, in this case repeated courses of therapy have failed to eradicate the larvae from the stool, though their number has been markedly decreased. This is unusual[6] in this infection which has been regarded as having cure rates[7] approaching 100 per cent with this agent.[8]

The use of corticosteroids is common in ulcerative colitis, but has been described[9] as inducing significant mortality in patients with strongyloidiasis. This is presumably due to a disturbance in the host parasite relationship and exacerbation of the disease by endoautoinfection.[3] Consequently, in any patient with ulcerative colitis who has been in an endemic area for strongyloidiasis, corticosteroid therapy should be undertaken only after careful search for strongyloides larvae has been made and appropriate therapy has been given. This is especially true if the colitis cannot be definitely dated as having had its inception prior to travel to the endemic area. This may prove to be an important consideration in veterans returning from Vietnam as well as in patients, such as the one described herein, who were born in the West Indies.

† Thiobendazole is an antihelminthic available under the Merck tradename of Mintezol.

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512 East Broad Street

Apart from scaring the patient, the "functional" heart murmur seems innocent enough—when checked a decade later.

The Fate Of The Innocent Murmur*

Christiane F. Lange, M.D. and Gerald E. Muehsam, M.D./Orange

Since George Frederic Still[1] described the functional (or "innocent") systolic heart murmur in 1905 a great deal of discussion has taken place about the nature and identification of these murmurs as well as their incidence and course. The literature gives data concerning the characteristics of such innocent heart murmurs, but there are relatively few studies providing information on their later fate. We do know, that the incidence of innocent systolic murmurs is high in children and adolescents. Data vary widely as to their persistence as the bearer grows older, and statistical documentation is infrequent and contradictory.

This difference of opinion led to our present study, with the hope of gaining further information on the persistence or loss of innocent heart murmurs from adolescence to adulthood. The material for such a study seemed to be readily available in the School of Nursing associated with the Hospital Center at Orange.

The health records of 473 former student nurses from the years 1955 through 1968 were reviewed. In 63 a heart murmur had been noticed on one or several occasions over a period of three years and four examinations. Age at the time of the initial period of observation ranged from 18 to 20 years. Every examination was carried out by a staff physician and included a meticulous physical examination, postero-anterior and lateral chest x-ray, basic laboratory work, and, in four instances an electrocardiogram. These examinations were within normal limits, and the heart murmur was considered "innocent." These 63 girls were asked to return for a reexamination of their cardiovascular system. Eventually 26 of this group responded. Five nurses had moved out of the area and, therefore, were not able to take part in the study, three had changed addresses and/or names and could not be located, and 28 refused for "personal" reasons. One nurse was excluded because she was nine months pregnant.

The present follow-up examination consisted of:

1. Review of the past history especially concerning childhood diseases with stress on tonsillitis, tonsillectomy, scarlet fever, and rheumatic fever

2. Interval history from the last to the present examination

3. Present history in relation to cardiovascular disease

4. Physical examination by two physicians

5. Electrocardiogram—12 leads

6. Chest x-ray in postero-anterior and lateral views with barium-swallow

7. Phonocardiogram with recordings at three different frequency levels and a standard lead II electrocardiogram for timing purposes. The recordings were obtained over the point of maximum intensity of the murmur on auscultation.

To the best of our knowledge only one nurse was pregnant at the time of examination (16 weeks of gestation).

* From the Ewing Cardiac Unit, The Hospital Center at Orange, New Jersey

Results

We communicated with 63 nurses and 26 were examined as described above. Time span between the first examination (on entering the school as a student nurse) and the present reevaluation varied from 4 to 18 years, on the average nine years of follow-up. Fourteen women fell into a time span of 5 to 8 years.

Age distribution varied similarly: The youngest nurse was 22 years old, the oldest 35, the average age being 27. Age at first detection of the murmur ranged from early childhood to rather recent dates. Two nurses remembered that their murmurs had been found at the age of 2 and 5. Two others knew that the murmur had been there "since early childhood," but a more accurate date could not be elicited. Six had been diagnosed at a much older age, between 11 and 17 years, but before entry to the School of Nursing. Six had no knowledge of a heart murmur prior to receipt of the follow-up letter. The rest of the murmurs (seven) had been found on the "routine" examinations between the ages of 18 and 20.

Past histories were unremarkable in most instances. Thirteen had a history of tonsillitis, eleven had undergone tonsillectomy as children or adolescents. None gave a history of rheumatic fever or its equivalents, but two had had scarlet fever at the age of 5 and 13. Interval histories were uneventful in all but three. One woman had unilateral oophorectomy. One had scleroderma while she was still a student nurse, but had had no recent difficulties with it. One was on corticosteroid treatment for menstrual irregularities at the time of the study. Fourteen nurses had married in the interval and had had 30 uneventful pregnancies and deliveries. All nurses were found to be in good health. Symptoms suggestive of cardiovascular disease could not be detected, but two nurses related having palpitations on excitement.

Original findings in the health records showed that:

Eight murmurs were best heard in the pulmonic area.

One murmur was found in the aortic area. (Three of these nine murmurs were transmitted to the neck.)

Nine murmurs were heard along the left sternal border.

Eight had maximal intensity in the apical area.

Twelve murmurs were listed as grade 1/6, eleven as grade 2/6, and three as grade 3/6.

None of the students had any arrhythmias or arterial hypertension.

Follow-up Examination

Follow-up of 26 nurses revealed murmurs in 23. Ten were best heard over the second intercostal space at the left sternal border. Three of these were transmitted to the neck, three downwards along the left sternal border, and three were also audible in the apical region. Eight murmurs had their maximal intensity over the third left intercostal space, with transmission along the left sternal border and toward the apex in six. The five remaining murmurs were located at the lower left sternal border over the fourth intercostal space, two of which could also be appreciated at the apex.

In eight nurses physiologic splitting of the second heart sound was present and confirmed by phonocardiography.

All murmurs were of rather low intensity, thirteen were graded 1/6, eight 2/6, and two 3/6. Twelve of the 26 were of low frequencies. Four consisted mainly of high frequency vibrations. The remaining seven were recorded at medium high frequencies. Except for one murmur, all were of the *decrescendo* type and usually followed immediately after the first sound. This was not so in four instances where there was a pause between the first sound and the onset of the murmur of 0.01 to 0.04 seconds.

One murmur was "diamond shaped" and started 0.04 seconds after the first sound, thus occupying mid-systole. Duration of the murmurs varied from 0.04 to 0.17 seconds, the average being 0.10 seconds. These values show that the murmurs occurred in early systole and were of short duration, usually being

found in the first third of systole. No diastolic murmurs were heard or recorded on the phonocardiograms. All electrocardiograms and chest x-rays were normal.

Interpretation

The significant findings in the present study and its comparison with the previous examinations are:

(a) Three murmurs out of twenty-six could no longer be demonstrated.

(b) Ten murmurs were still found over the second left intercostal space. Eight were recorded along the left sternal border instead of originally nine, and five were in the apical area. The radiation to the neck or apex was found as frequently as in the original examination.

(c) The incidence of "innocent" heart murmurs in a group of 473 student nurses between the ages of 18 to 20 years was sixty-three or 13 per cent. Follow-up examinations of 26 nurses 4 to 18 years later showed that twenty-three or 88 per cent still have the same murmurs.

Comment

Experiences about the incidence and fate of the "innocent" systolic heart murmur, in the medical literature, vary widely. Segal[2] said the incidence in children is 25 to 50 per cent. "They tend to disappear as the child matures," he added. Shapiro[3] followed 102 children over an average period of 4.6 years, and found a persistence of the murmur in 98 per cent. But Marienfeld[4] reevaluated 96 persons after 20 years and stated that 80 per cent of the patients had lost their systolic murmur. Weaver[5] reexamined 100 young adults after 16 years or more and found that 85 per cent of the systolic murmurs were still present. Thus opinions about the nature of these murmurs differ as much as the documentations of their incidence.

Still[1] did not give any explanation of the mechanism of the murmur. Later investigators suggested various theories:

Caceres and Perry[6] cited a list of possible causes in their book *The Innocent Murmur*, based on anatomic explanations such as vibrations of the cardiac walls, the large vessels, and adjacent tissues or disproportion between valve area and volume of blood flow. Humphries and McKusick[7] felt that " . . . the normal flow of blood through a normal valve area may also produce an ejection murmur, . . . functional in nature . . . generated by flow through a normal right ventricular outflow tract or pulmonary valve . . ." Harris suggested that ". . . they may be due to free vibration of some anatomic structure in the heart, this vibration being caused by the impact of a fluid mass or sudden pressure change in the course of the normal hydrodynamic changes in the heart . . . ".

Most authors are convinced that systolic murmurs without objective and subjective evidence of cardiovascular disease do exist. However, Levine[9] stated that most of the systolic murmurs, though unchanged over long periods of time, are *always* associated with some form of cardiovascular disease. Luisada[10] suggested that these murmurs are due to organic changes or indicate potentialities for the subsequent development of heart disease.

Our study of 26 women with systolic heart murmurs of at least 8 years duration fails to document a significant loss of these murmurs over the years of observation. On the other hand no sign of cardiovascular disease of any kind could be detected. After restudy of these murmurs by means of clinical and phonocardiographic evaluation by two examiners it was concluded that these murmurs fulfill the criteria of the so called innocent or functional type, namely: systolic in time and of short duration, maximal intensity along the left sternal border with little or no transmission, no thrills or abnormal first and second sounds, physiologic splitting of the second sound, and normal electrocardiographic and chest x-ray findings.

Summary

Twenty-six women, age 22 to 35, with "innocent" heart murmurs of at least 8 years duration were examined after an average interval of nine years to document the incidence of such murmurs. Three murmurs or 11.5 per

cent had disappeared. In the others, the murmur remained essentially unchanged. None of the women presented signs of a cardiovascular disorder of any kind.

Acknowledgement: The cooperation of the director of the School of Nursing, Miss C. M. Howard, and the health nurse, Mrs. E. Damiano, is greatly appreciated.

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188 South Essex Avenue

Drug Abuses In Industry

Three out of every four U.S. plants with 50 or more employees have a serious drug problem, according to a survey taken by Chicago's *Industrial Relations Newsletter.* Attorney General Mitchell estimates that one out of every 40 workers in the U.S. uses drugs illegally. The Research Institute of America (RIA), a private research group, says that drug abuse in the business world exists at a "startling extent" and that it is "ominously growing." No longer are the heroin syringes, grass, or pills confined to the streets of our ghettos or to college campuses.

The RIA survey in the New York area found that most companies expected to uncover three times as many addicts in their work force by the end of 1970 as in 1969. Drug abuse is becoming increasingly expensive to business. In the RIA survey, turnover due to the release of addicted employees cost one company $75,000 in 1969. Other industries' losses included absenteeism, poor work performance, higher insurance rates, and an inevitable increase in taxes to support facilities needed to handle drug abusers.

Some companies are now requiring physical examinations, including analysis of urine for drugs, both for new applicants and for those employed. One company in the RIA survey reported that in screening new applicants 25 per cent of the urines tested showed drug abuse.

One of the laboratories specializing in analysis of drugs of abuse is here in New Jersey.* It serves private industry as well as public agencies such as police departments. Most of the private laboratories are equipped to test urine and other materials for the presence of drugs of abuse, including opiates, amphetamines, and barbiturates. Presence of the drugs may usually be detected in the urine 48 to 72 hours after the administration of a dose.

Dr. Mitchell Rosenthal, director of New York City's Phoenix House suggests that, eventually, business will have to take a more active role in aiding drug-dependent workers and in helping to support adequately staffed treatment centers. "Not until private industry realizes that the drug user is increasingly bright, and often 'middle class,' is it likely to take a rehabilitative approach to drugs," says Dr. Rosenthal.

* Eastern Analytic Laboratories, Inc., Loden, New Jersey

Made known here is the most widespread epidemic of erythema infectiosum ever reported in our state.

Erythema Infectiosum: A Statewide Outbreak*

Richard N. Edelson, M.D. and Ronald Altman, M.D./Trenton

Throughout the United States and Europe, outbreaks of erythema infectiosum, or "fifth disease," have occurred in localized populations, such as communities and schools. In 1968, erythema infectiosum was found in almost the entire state of New Jersey. Here is a report of this statewide outbreak and a study of one typical school population involved in this outbreak.

Erythema infectiosum was first described as a distinct clinical entity in the late nineteenth century.[9] The earliest report in the American literature was in 1905, when Shaw[8] detailed cases he had observed in Vienna during the previous year. In 1905, the illness was designed as "fifth disease" by Cheinisse.[3] (The first "four diseases" are rubeola, scarlet fever, rubella, and Dukes' Disease.[4])

Outbreaks of erythema infectiosum occurred in St. Louis[11] in 1924, in Cleveland[5] in 1924-26, and in Branford, Connecticut[6] in 1930. The authors of these reports emphasized that the illness was a distinct clinical entity, appearing in epidemics, and characterized by a rose-red evanescent eruption in the absence of other symptoms. The largest reported outbreak was in Port Angelis, Washington,[1] where 667 suspected cases were reported in 1962.

The etiologic agent of erythema infectiosum has never been identified. The disease is assumed to be of viral etiology.

Erythema infectiosum is a contagious disease. Most outbreaks are found in groups with close personal contacts, such as families or schools. The illness can occur at any age, but it mainly involves children between the ages of 3 and 12. No sex predilection has been reported. The incubation period is from 4 to 14 days. Its outstanding feature is an outbreak of an illness characterized by an erythematous rash with almost no other symptoms. Occasionally, patients have low-grade fever, some gastrointestinal distress, headache, or sore throat. Adult patients frequently have arthralgia with erythema infectiosum.

The rash is generally described as occurring in three stages.[10] The *first*, which lasts 4 or 5 days, is characterized by fiery red cheeks with circumoral pallor. This symmetric confluent macular rash covers the malar eminences and frequently involves the bridge of the nose. The exanthem is described as having a "slapped cheek" appearance. The skin is hot, and the color blanches on pressure.

The *second* stage usually begins a day or two after the end of the first stage and consists of a macular rash involving the extensor surfaces of the arms and legs. The rash may subsequently spread to the neck, chest, and buttocks. The eruption is generally not as bright as that of the face. The rash assumes a blush-red appearance and forms a lace-like pattern which spreads distally. Pruritis has varied in different series[1, 10] from 15 to 63 per cent.

* From the Division of Preventable Diseases, New Jersey State Department of Health and the National Communicable Disease Center, Public Health Service, U.S. Department of Health, Education and Welfare. Reprint requests should be directed to Ronald Altman, M.D., New Jersey State Department of Health, P.O. Box 1540, Trenton, New Jersey 08625

The *third* stage is ushered in by fading of the rash. This stage lasts up to three weeks, and is characterized by periodic evanescence and recrudescence of the rash, which is likely to appear during exercise, a hot bath, or exposure to sunlight. This fluctuation of the rash is an important feature of the clinical course of erythema infectiosum. The rash has no sequelae, and desquamation is rare.

The New Jersey 1968 Outbreak

Over the past decade, reports of isolated outbreaks of erythema infectiosum in New Jersey have been received by the New Jersey State Department of Health. Epidemiologic and laboratory investigations of many of these outbreaks have been performed by this Department. The first 1968 report of erythema infectiosum in New Jersey came in January from Morris County. By March, clusters had also been reported from Middlesex, Burlington, and Union Counties.

Erythema infectiosum is not a reportable disease in New Jersey. Further to document its distribution throughout the State, the Communicable Disease Control Program of the State had to initiate a mechanism other than traditional disease reporting. In May 1968, a letter was sent to all physicians and local health officers in New Jersey, describing the clinical symptoms of erythema infectiosum and asked them to notify the Communicable Disease Control Program of suspected cases. Similar letters were sent to school nurses in the public and parochial schools throughout the State.

Throughout May and June, 1968, physicians, health officers, and particularly school nurses reported cases of erythema infectiosum to the State Department of Health. Whenever possible, a member of the Communicable Disease Control Program visited representative cases from the reported clusters and collected blood, throat washes and stool specimens for serologic and viral isolation studies, which were performed by the Virology Laboratory of the State Department of Health. In all, 1,675 cases of erythema infectiosum were reported, almost all the patients were children. Cases were reported from 216 of the 567 municipalities in New Jersey and from all counties except Hunterdon and Cape May.

No etiologic agent was determined from the virologic and serologic studies performed on the patients with erythema infectiosum in New Jersey.

School Survey

In February 1968, the nurse of a parochial school in Middlesex County notified the Communicable Disease Control Program that 20 children in her school had an undiagnosed rash. We visited the school and diagnosed the illness as typical erythema infectiosum.

The school had a population of 1,140 pupils in eight grades. Ages ranged between 6 and 14 years, with essentially equal sex distribution. A questionnaire was sent home with each pupil in weeks 7 and 12 of the outbreak and collected in weeks 9 and 14. The questionnaires were returned by 97 per cent of the pupils.

It thus appeared that 213 pupils had a rash illness between February and May 1968, for an attack rate of 19 per cent. In the first three grades, the attack rate was 25 per cent. In the other five grades, the attack rate was 15 per cent (see Table I).

Within individual grades, the highest attack rate was 40 per cent in a third grade class, the lowest 2 per cent in an eighth grade class. There were 129 cases among the 561 girls, for an attack rate of 23 per cent, and 84 cases among the 551 boys, for an attack rate of 15 per cent.

As the symptoms were noted retrospectively by the parents, there was probably some inaccuracy in the reporting. The reported symptoms are tabulated in Tables II and III.

Four teachers and one other employee, representing about 10 per cent of the adult staff, also reported an illness compatible with ery-

Table I

Erythema Infectiosum
New Jersey Parochial School
Attack Rate by Class

Grade	Class	Number of Students Returning Questionnaires	Number of Cases	Class Attack Rate (%)	Grade Attack Rate (%)
1	A	44	14	31.8	25.4
	B	47	10	21.3	
	C	47	11	23.4	
2	A	53	16	30.2	24.4
	B	55	14	25.5	
	C	52	9	17.3	
3	A	47	19	40.4	25.9
	B	52	6	11.5	
	C	48	13	27.1	
4	A	49	11	22.4	16.8
	B	49	5	10.2	
	C	51	9	17.6	
5	A	49	8	16.3	21.0
	B	51	10	19.6	
	C	5	4	80.0	
6	A	55	7	12.7	13.6
	B	42	8	19.0	
	C	50	5	10.0	
7	A	43	8	18.6	19.0
	B	49	14	28.6	
	C	45	4	8.9	
8	A	43	3	7.0	6.2
	B	42	1	2.4	
	C	44	4	9.1	

TABLE II

New Jersey Parochial School—1968
Erythema Infectiosum
Anatomic Distribution of Rash

Part of Body Involved	Number of Patients	Per cent of Patients
Arms	152	71.4
Legs	123	57.7
Face	106	49.8
Abdomen	91	42.7
Back	69	32.4
Mouth	4	1.9
Buttocks	1	0.5

*213 patients reported rash.

TABLE III

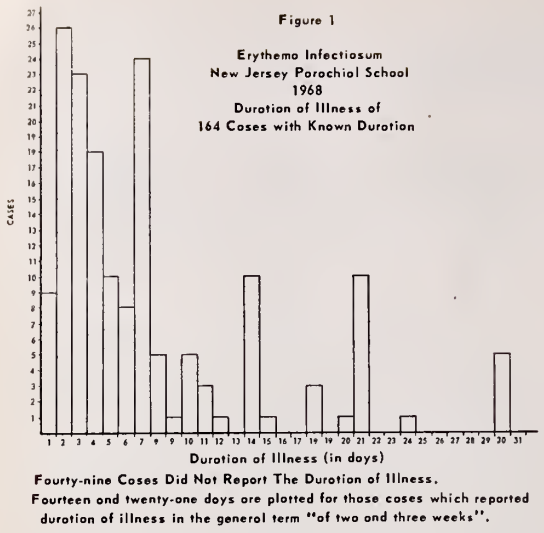
Erythema Infectiosum
New Jersey Parochial School—1968
Symptoms

Symptom	Number of Patients* Reporting Symptom	Per cent of Patients Reporting Symptom
Related to Rash		
Pruritus	121	56.8
Rash "comes and goes"	112	52.6
Rash increases on exposure to sunlight	92	43.2
Not Related to Rash		
Headache	47	22.1
Sore Throat	44	20.7
Sore Eyes	26	12.2
Abdominal Pain	25	11.7
Runny Nose	23	10.8
Fever	23	10.8
Nausea	15	7.0
Vomiting	9	4.2
Diarrhea	8	3.8

*213 patients reported rash.

thema infectiosum. Two of these teachers had joint pains. One had pain on the ulnar aspect of her left hand and wrist and the other had pain and swelling in her wrist and ankles.

The parents were questioned about the dura-



tion of the rash. The duration ranged from one to 30 days (Figure I).

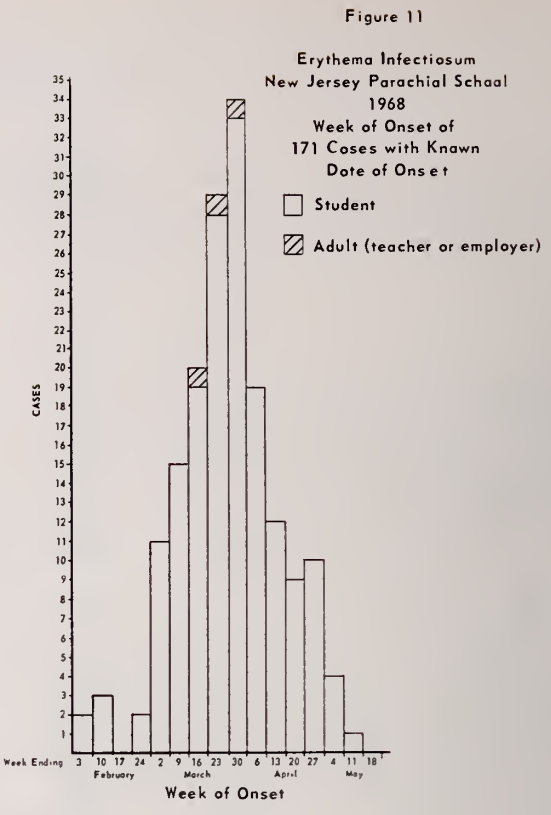
The exact length of the epidemic could not be determined, as the first questionnaire asked for cases beginning in March, and cases occurred prior to the time. The second questionnaire was collected during the first week in May, and cases are known to have occurred after that time. According to the questionnaires, the epidemic lasted 14 weeks, with the peak of illness occurring in the ninth week

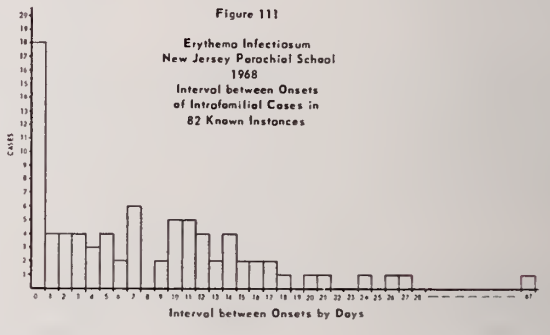
(Figure II). The spread of the illness did not appear to be halted by the Easter vacation, in the eleventh week.

On 52 per cent of the questionnaires, more than one rash illness in the household was noted. These secondary cases developed in family members who were not necessarily parochial school students. The interval between onset of intrafamilial cases is shown in Figure III. All except one of the cases occurred within four weeks of the initial case, most occurring in the first two weeks. One pupil who had been on a trip out of the country developed erythema infectiosum four days after his return.

Discussion

During the winter and spring of 1968, erythema infectiosum occurred throughout most





of New Jersey. This represents the most widespread occurrence of this disease that has been reported, with 1,675 cases being made known to the New Jersey State Department of Health as a result of our letters. The actual number of cases probably far exceeds this number.

A detailed study of one school showed some interesting relationships. The incidence of pruritis in 57 per cent of the children agreed with those outbreaks[1, 2, 7] where pruritis was reported in about 60 per cent of the patients. Also of interest is the age distribution, with fewer cases in the older age groups. This

would suggest either immunity to the disease in this age group or higher inapparent infection to disease ratio among the older children. This would not be amenable to verification until laboratory tests are available for the agent of erythema infectiosum. Also of interest was the distribution of cases in this school, with many more females affected than males. The reason for this is not apparent. The contagiousness of the disease is well documented by the fact that there were many intrafamilial secondary cases.

Erythema infectiosum is an illness which would not generally be recognized except in outbreaks. The rash can be confused with other exanthemata, and although the paucity of other symptoms suggests erythema infectiosum, other entities can produce a similar clinical picture. If it occurs with some frequency in the community, the disease can be easily recognized. Since rubella, mild scarlet fever, and allergic rash are conditions most frequently confused with erythema infectiosum, early diagnosis precludes needless treatment and anxiety on the part of the patients and their families.

Summary

Between January and June 1968, 1,675 cases of erythema infectiosum were reported from 19 of the 21 counties in New Jersey. This represents one of the most widespread outbreaks ever reported of this disease. A survey was done in one elementary school which yielded an over-all attack rate of 19 per cent with higher attack rates in lower grades. At least a 14 week duration of the outbreak was found, which, along with many secondary infections, suggest a person to person spread of the etiologic agent.

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Acknowledgement—We wish to thank Josephine Blaszka, R.N., Public Health Nurse in Edison Township, without whose help the school survey could not have been accomplished.

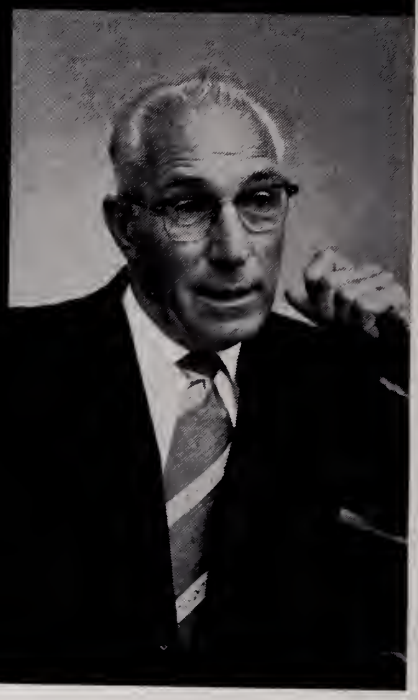
P.O. Box 1540

The Illness Called Alcoholism

A 16-page brochure, developed for the benefit of the laity, defines alcoholism and delves into its causes, effects, identification, and treatability. It stresses that alcoholics *can* be treated successfully and that they are not to be considered "hopeless cases." The name of this brochure is "The Illness Called Alcoholism." What role can a responsible citizen play in the alleviation of this problem? One method suggested is to persuade a suspected alcoholic to see his physician. Attempts to conceal drinking and refusal by an individual to admit that he drinks excessively are two of the numerous symptoms listed to aid in the detection of possible alcoholism.

A complimentary copy of this new pamphlet may be requested by the code number OP-192 from the AMA Department of Health Education, 535 North Dearborn Street, Chicago, Illinois 60610. Quantity prices are as follows: 1-49 copies, 20¢ each; 50-99, 18¢ each; 100-499, 16¢ each; 500-999, 14¢ each; 1,000 or more, 12¢ each.

"Drug research gives me the tools that save lives."



A family doctor looks at new developments in the pharmaceutical industry. And he speculates on the future.

When I look back at some of my old records, I'm constantly reminded of the changes that have come about in medicine just during the past twenty-five years. Some of the diseases I treated and prayed over in the '40's are found mostly in medical history books now.

Thanks to drug research and development, we've made substantial gains in the control of cardiovascular disease, diabetes, malaria, mental illness, strep and staph infections, meningitis and a long list of ailments. It seems like only yesterday when a diagnosis of pneumonia was almost the kiss of death. Now, with modern medical techniques and drug therapy, we can offer some real help.

My records on polio, influenza and measles show an unbelievable trend for the better. New vaccines have reduced the toll of these age-old threats dramatically. And I see patients in pain from crippling arthritis helped with new medicinals unknown just a few years ago.

I hear questions about the three billion or so dollars spent by the drug industry in research during the past ten years . . . working on new and better drug products. It does seem like quite a bit of money to spend, and I realize some of it goes into dead ends. That's the problem with research, any research . . . you often don't know where you're going until you get there. I want all the tools I can get to help my patients. I want more drugs and more effective drugs. If they mean less pain, longer lives and more productive careers for those I treat . . . well, that's what really counts.

Another point of view . . . Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.

This advertisement has been reaching consumers thru THE ATLANTIC, FAMILY HEALTH, HARPER'S MAGAZINE, NEWSWEEK, SATURDAY REVIEW, TIME and U.S.NEWS & WORLD REPORT.



Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

THE STOPPER



LOMOTIL®

tablets/liquid

Each tablet and each 5 cc. of liquid contain:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

first aid in diarrhea of acute gastroenteritis

PROMPT ANTIDIARRHEAL ACTION
Roentgenographic studies demonstrate that the motility-lowering activity of Lomotil is concentrated in the first three hours and continues for at least six hours.

Clinical investigators have found ample confirmation of these determinations. Lomotil has reduced diarrheal urgency in many patients within one hour.

OPTIMAL ANTIDIARRHEAL CONTROL
Numerous investigators have remarked on the high degree of effectiveness of Lomotil in a variety of diarrheal disorders. Lomotil has given good to excellent relief of symptoms in many patients who had failed to respond to other measures.

UNSURPASSED ANTIDIARRHEAL ACCEPTANCE
Patients prefer Lomotil for its convenience, its prompt control of diarrhea and its relief of cramping and urgency. Physicians specify Lomotil for its dependable action and its relative freedom from side effects when taken as directed.

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:

3-6 mo. ..½ tsp.* t.i.d. (3 mg.)
6-12 mo. ..½ tsp. q.i.d. (4 mg.)
1-2 yr. ...½ tsp. 5 times daily (5 mg.)
2-5 yr. ...1 tsp. t.i.d. (6 mg.)
5-8 yr. ...1 tsp. q.i.d. (8 mg.)
8-12 yr. ..1 tsp. 5 times daily (10 mg.)
Adults: ...2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

953

G. D. SEARLE & CO. • P.O. Box 5110, Chicago, Illinois 60680 • Research in the Service of Medicine

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories

Some medical practitioners are baffled by their attitudes toward a patient's previous therapist. Here is a psychiatric view of this problem.

The "Other" Therapist

Irving Markowitz, M.D./East Orange

When seeing patients who are or have been in therapy with other psychiatrists, it has been my policy to be no more and no less "analytical" of that relationship than any other significant relationship in the patient's life. Since the therapist is a relatively secure public figure, his discourse with the patient may be considered even less immune from scrutiny than that with more vulnerable private figures. Although a previous therapist's utterances deserve courtesy, they do not necessarily deserve "professional courtesy."

To distinguish ethics from unionism requires the second therapist to consider whether he is trying competitively to minimize the other therapist's contribution or whether he is too cowardly to challenge any member of the guild for fear of jeopardizing his own position there. Often therapists have retorted to their patient's attacks upon previous therapist with such comments as: "Did he say that?" "You must have misunderstood." "He's a very reputable therapist." Faint praise may do more to damn the previous therapist than forthright criticism since the careful refraining from derogatory comment immediately establishes the new therapist as a superior being whose motives are beyond question.

What the previous therapist said or did not say is a matter of unrecorded history. To attempt interminably to elucidate the exact truth of what was meant or not meant is to attach an unwarranted significance to the lasting traumatic effect of the therapist's utterances upon the patient's life. The patient may, as a result, find it difficult to forgive his previous therapist and move on to develop his own resources. If the patient chooses to spend time analyzing his previous therapeutic relationship, the new therapist must respect the patient's choice as an indication of unresolved problems meriting discussion. By setting a time limit for such discussion, the therapist helps give proper weight to the lasting effects of any human relationship.

If the recollections of a patient are false, all the conclusions reached are false. The therapist is as much the prisoner of this obfuscation as the patient. In any encounter there are two pathologies. To focus on the pathology of the patient is to encourage the grandiosity of self-vilification. To focus on the pathology of the therapist is to encourage the grandiosity of blamelessness. The pathology, however, of the previous therapist is only of passing concern. The pathology of the patient is and will be a continuing subject of thoughtful research.

Nothing of what has been said so far precludes the therapist from searching feverishly for whatever he can find that was praiseworthy in the previous therapist's activity.

If a patient is to have any hope of change while preserving some few of his cherished differences from other human beings, a new human relationship cannot be an exact duplicate of his previous ones. If, wherever he turns in therapy, he comes upon the same technics and viewpoints, the paradox he may be asked to accept is that uniformity and freedom are synonymous. If all therapists are alike, the possibility that difference may have survival value becomes more remote.

One patient had consulted twenty other therapists, including many of my own mentors before coming for consultation. Except

for one, whom she saw for six months, she had seen the others for at most, five sessions. She stated that the long-lasting therapist had benefited her most, but could not remember his name, although she did remember the names of all the others. She inveighed against the inhumanity of therapy and the heedlessness of the world to her "simple" requirements. I did not deny the inhumanity of therapy but did question in the first interview why she persisted in seeking in "inhuman therapy" what she had not been able to find in her outside more "human relationships," pointing out, too, that orgasm did not require a perfect fit. In the course of therapy, the patient lost most of her symptoms, divorced, remarried and was briefly a member of a therapeutic group. In none of these activities was she able to find a fit that provided long-lasting satisfaction. She had every right to search for a fit and that much of what she sought was desirable; but I disputed that it was economically attainable. Although much effort was expended in trying to understand fully, why she was unable to make the most of what existed, no insight she has gained so far, and no warmth that she has experienced has enabled her to acknowledge satisfaction. The problem of the inveterate shopper is not that they shop but that they never buy.

A young successful physician has been in regular therapy with a female psychoanalyst for several years. In moments of depression he had called me for an appointment so that he has been seen at least once every second month for the past two years. He has brought in many dreams that had already been discussed with his regular therapist, promoting several discussions of the virtues and defects of being a dream interpretation comparison shopper. Whatever neurotic elements there are in matching mama against papa, the patient has felt benefits that never accrued prior to this procedure. Neither his regular therapist nor the writer have voiced any opposition to this somewhat unorthodox practice. So far, there has been no collaboration, collusion, or collision. The results seem happier than in many situations where active collaboration was attempted. In most life situations, human beings need new sources of wisdom to face new crises. When they are unable or prevented from so doing, they are more likely to remain depressed than when freedom of choice is encouraged. Neither of his therapists have felt they diluted each other's wisdom. At no time has the patient adversely criticized the other therapist. Had he felt more competition or more restriction, he would have been more critical of both therapists, if only to assert his right to freedom. He has pointed out areas of warmth lacking in his second therapist, which the other therapist furnishes but has been tolerant of these deficiencies. He has also gratefully acknowledged unique contributions to his welfare but has not condemned the other therapist for her failure to be equally helpful.

Unless therapists can accept one another sufficiently to be appropriately critical of each other's foibles without characterizing such foibles as complete barriers to helping patients, we are likely to teach our patients to hide what they cannot alter instead of struggling for greater freedom and productivity.

115 South Munn Avenue

205th ANNUAL MEETING

Scientific Exhibit Application

See Page 823

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

October 18, 1970

A regular meeting of the Board of Trustees was held on October 18 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Tuberculosis Patients in General Hospitals . . . Adopted the following recommendation from the Public Health Council:

That MSNJ endorse, in principle, the policy statement concerning "Treatment of Tuberculosis Patients in General Hospitals" as adopted by the Tuberculosis-Respiratory Disease Association of New Jersey on February 4, 1970

Proctosigmoidoscopy Examinations . . . Adopted the following recommendation, as amended by the Board, from the Council on Public Health (Committee on Cancer Control). This had been prepared after it was learned that the fiscal intermediary for Medicaid/Medicare had been denying proctosigmoidoscopies as not medically indicated:

That the Board of Trustess advise the fiscal intermediary responsible for monitoring services to Medicaid and Medicare patients, that proctosigmoidoscopic examination is an indicated procedure for patients over 40 years of age and should not therefore be categorically dismissed as "not medically necessary."

Scientific Exhibits . . . Approved, as amended, the report of the Sub-committee on Scientific Exhibits, including the following recommendations:

1. That the application form and regulations governing scientific exhibits be reprinted for 1971 with one minor change—advancing the date for receipt of applications from 15 January to 1 January 1971.

2. That the following scientific exhibit awards be made in 1971:

a. First and second place award plaques and third place gold seal certificate for New Jersey exhibitors.

b. First and second place award plaques for out-of-state exhibitors.

c. Special Award Plaque from the Committee on Scientific Exhibits to be presented to a New Jersey exhibitor.

d. Three Honorable Mention certificates each to be presented to New Jersey and out-of-state exhibitors.

e. Certificate of merit and $50 check to be presented to *a* student from *each of* New Jersey's two medical schools.

3. That the award presentations for the most outstanding scientific exhibits be made *as the first order of business* at the third session of the House of Delegates on Tuesday, 18 May 1971. (Underscoring indicates amendment by the Board of Trustees.)

Informational Exhibits . . . Approved the following recommendation concerning the presentation of informational exhibits:

That informational exhibits be accepted only on the condition that the exhibitor pay $150 per 10 feet of booth space. (This would not include councils and committees of MSNJ.)

Joint Conference of Presidents . . . Met with members of the Conference of County Presidents (17 County Societies represented) and discussed the following items: (1) replacing one of the semi-annual meetings of the Conference with the Board with a meeting of the Board and chiefs of hospital staffs—vetoed by the Conference; (2) activities concerning the area of religion and medicine at the county level; (3) inclusion of arbitration clauses in hospital consent forms; (4) a more aggressive approach in handling malpractice claims—urging exploration of the subject by MSNJ's delegates to the AMA Clinical Convention in Boston; (5) progress concerning implementation of Resolution #9—Legislative Approach to Malpractice—approved by the 1970 House of Delegates; (6) Assembly Bill 802 (defeated) which would have established the legal status of medical-technical ancillary personnel—a similar bill will be reintroduced; (7) the chiropractic problem; (8) the Bennett Amendment which is a "peer review" proposal attached to the Society Security amendments of 1970 (this would require the secretary of HEW to set up committees of physicians and other personnel who would review all medical and hospital care given under Medicaid/

Medicare, including passing upon pre-hospital admissions); (9) the means for transferral of HSP-MSP coverage to an individual policy for widows or families of deceased members of MSNJ; and (10) use of a nurse-practitioner in the pediatric department of a hospital. The Board had previously considered this matter (20 September 1970) and had neither approved nor disapproved such a procedure, but rendered at that time, the opinion (concurred in by Legal Counsel) that this was not in contravention of the Medical Practice Act, since the person would be a registered nurse carrying out duties assigned by the licensed physician in charge of the case.

Vacancy on Council on Legislation . . . Appointed John J. Crosby, Jr., M.D. of Hudson County as an interim member of the Council on Legislation to fill the unexpired term of Louis Kosminsky, M.D. (2nd District—1973) until the 1971 meeting of the House of Delegates.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY—Lawrence K. Harris, M.D., 70 Maplewood Drive, Maple Shade 08052. Dalhousie (Nova Scotia) 1965. Board eligible. Hospital or Group. Available July 1971.

FAMILY PRACTICE—Joseph P. Chollak, Jr., M.D., 132 South Franklin Street, Wilkes-Barre. Pennsylvania 18702. Jefferson 1967. Group. Available, August 1971.

OBSTETRICS AND GYNECOLOGY—Ira Bernstein, M.D., 660 East 98th Street, Brooklyn, New York 11236. New York Medical 1966. Board eligible. Partnership or solo. Available, June 1971.

Yurdakul Omay, M.D., 2106-R West Otley Road, Peoria, Illinois 61604. Ankara (Turkey) University 1956. Salaried, group, or partnership. Available.

OPHTHALMOLOGY—Stephen H. Franklin, M.D., 555 East William Street, Ann Arbor, Michigan 48108. NYU Downstate 1963. Solo or association. Available, March 1971.

Jose Minaya, M.D., 1106 Lyndon #10, Houston, Texas 77025. San Marcos (Lima, Peru) 1962. Board eligible. Group or partnership. Available.

Elia S. Toueg, M.D., 239 East 79th Street, New York 10021. Cairo University, UAR, 1950. Board eligible. Salaried, group, or partnership. Available December 1970.

F. K. Michail, M.D., 676 Park Avenue, East Orange, New Jersey 07017. Cairo University, UAR, 1960. Board eligible. Partnership. Available December 1970.

Donald A. Feretti, M.D., 1865 Old York Road, Abington, Pennsylvania 19001. Hahnemann 1964. Board eligible. Group or partnership. Available July 1971.

OTOLARYNGOLOGY—Bardev Kapila, M.D., 142-20 84th Drive, Jamaica, New York 11435. Amristar Medical College (India) 1960. Board certified. Group, partnership, or solo. Available.

PEDIATRICS—L. Arshad, M.D., 5735 Kings Highway, Brooklyn, New York 11203. Gandhi Medical (India) 1962. Board eligible. Group or partnership. Available.

Ayhan Erinc, M.D., 7101 South Adams Street, Peoria, Illinois 61607. Ankara, Turkey 1958. Board eligible. Group, Partnership. Emergency Room, House Physician available.

Philip H. Friedman, M.D., 287 Dickman Drive, Loring AFB, Maine 04750. NYU (Downstate) 1965. Board certified. Group or partnership. Available February 1971.

Ali Jahromi, M.D., 515 East 7th Street, Brooklyn, New York 11218. Tehran (Iran) Medical School 1968. Board certified. Solo or group. Available.

M. R. S. Parand, M.D., 11 Stephen Hopkins Court, Providence, Rhode Island 02404. Pahlavi (Iran) University 1959. Group, partnership, or solo. Available.

SURGERY—P. B. Dandade, M.D., At and PO, Undri District, Buldana, M.S., India. Nagpuv University (India) 1962. Board eligible. Subspecialty, thoracic and cardiovascular surgery. House physician, emergency room or group. Available as soon as visa granted—January 1971 or before if sponsored.

Mehdi B. Javan, M.D., 120 North Mole Street, Philadelphia, Pennsylvania 19102. Pahlavi (Iran) University 1961. Board certified. Subspecialty, cardiothoracic surgery. Group or partnership. Available July 1971.

Rodigo Vilar Blanco, M.D., Doctors' Hospital, East End Avenue, New York 10028. Santiago (Spain) 1953. Board eligible. Group or partnership. Available December 1970.

Rolf H. Bessin, M.D., 6136 East Pratt Street, Baltimore, Maryland 21224. George Washington 1964. Board eligible. Group or partnership. Available August 1971.

Alan I. Josephson, M.D., 23 Parkside Drive, Hanover 07936. Tufts 1962. Board certified. Group or Partnership. Available.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during October:

	1970 October	1969 October
Aseptic meningitis	56	35
Primary encephalitis	0	1
Post-infectious encephalitis	0	1
Hepatitis: Total	427	286
infectious	334	226
serum	93	60
Malaria: Total	4	18
military	4	14
civilian	0	4
Meningococcal meningitis	8	6
Mumps	72	89
German measles	12	27
Measles	4	38
Salmonella	76	62
Shigella	39	40

Measles

Measles (rubeola) in New Jersey has increased sharply during 1970. During the first 10 months of this year, 1639 cases of measles were verified by the New Jersey State Department of Health. This represents an increase of 742 cases (83 percent) over the 897 cases documented during the first ten months of 1969. Among the 1639 have been three cases of measles encephalitis and six of pneumonia. A total of 13 children have been hospitalized for complications of measles. The highest numbers of cases were observed during the months January through May. There was a decline in morbidity throughout the summer and early autumn months, with only 89 documented in the third quarter of 1970. Only four cases have been reported thus far in October. With the advent of winter, however, a dramatic rise in measles morbidity may be anticipated.

The aggressive measles surveillance program maintained by the State Department of Health is used to identify clusters of cases that reflect poorly immunized population groups. The State Department of Health is prepared to assist local and county health departments in conducting measles vaccination programs in areas where morbidity exists. Vaccine, supplies, and technicians utilizing hypo-spray jet injector guns are provided at no cost to either the municipality or individual. On the basis of extensive past experience, it has been found that the most effective immunization programs are those which are school based. Local agencies interested in conducting programs are urged to call either the Acute Communicable Disease Control Program or the Vaccination Assistance Program at (609) 292-7300 or (609) 292-5635.

German Measles

German measles (rubella) was declared a reportable disease in July, 1969 when rubella vaccine first became commercially available. Extensive immunization programs have subsequently been conducted by State, county, and local health departments. Thus far this year, 844 cases of rubella-like illness have been reported to the New Jersey State Department of Health. After completion of the state-wide immunization program this month, case reports will be used to identify populations with low levels of immunity. Rubella vaccination efforts will then be directed toward these areas to raise the general level of immunity, and thereby avert infection among susceptible pregnant women.

The ultimate goal in these intensive rubella immunization efforts is a reduction in the number of babies born with congenital rubella syndrome. Thorough and accurate surveillance of all infants born with congenital defects attributable to *in utero* rubella infection is necessary to provide this index. There were 38 cases of possible congenital rubella syndrome reported to the New Jersey State Department of Health in 1969, and two in which the diagnosis of congenital rubella syndrome was confirmed by serologic studies. Thus far in 1970 seventeen cases of possible congenital rubella syndrome have come to the attention of our department, but there have been no laboratory confirmations to date. For adequate surveillance, it is imperative that any patient with suspected congenital rubella syndrome be promptly reported, and appropriate laboratory tests performed.

Emergency Care Of Acute Drug Intoxication

Doctors responsible for emergency room care need a quick reference guide for persons who are reacting to abusable drugs with toxic symptoms. The table here presented was based originally on an item in the *Medical Letter,* and has been prepared in the form of this tabulation by Edward A. Wolfson, M.D., Associate Professor and Director of the Division of Drug Abuse of the NJCMD. This material was presented at the Pan-American Medical Association meeting in Ecuador in September 1970.

Acute Intoxication

Drugs	*Symptoms*	*Treatment*
Narcotics	Pupils pinpoint, fixed Blood pressure and respiration depressed Coma, shock, pulmonary edema Sensorium depressed, although some patients may be alert and appear normal	a) Pulmonary Edema—assisted respiration and narcotic antagonists b) Depressed Respiration—Same c) Shock—plasma expanders and/or pressor drugs
Central Nervous System Stimulants i.e. Amphetamines Phenmetrazine Methylphenidate	Pupils dilated, reactive to light Blood pressure elevated Cardiac arrhythmia Tendon reflexes hyperactive Sweating Occasional shallow and/or rapid respiration High fever Circulatory collapse Sensorium usually clear in milder cases; in severe cases, confusion, paranoid ideation, stereotyped activity, irritability, and aggressive behavior, especially after "speed" injections.	Chlorpramazine Support of vital functions
Psychedelics *LSD Type* i.e. STP, Mescaline Psilocybin *Cannabis* Marijuana Hashish THC *Anticholinergics* i.e. Atropine Scopolamine Belladonna Antihistamines	Pupils often dilated, reactive to light Reflexes occasionally hyperactive Anxiety Sensorium often clear Distortion of body image and of sensory perception Kaleidoscopic visual hallucinations, delusions Occasional synesthesia Pupils normal, conjunctivae red Sensorium often clear Distortion of perception and body image Hallucinations rare Alterations of time and depth perception Pupils dilated, fixed Flushed dry skin and mucosa Urinary retention Sensorium cloudy, disorientation Amnesia Visual hallucinations without perceptual distortion	Reassurance (talking down) If sedation necessary, use diazapam and/or barbiturates If blood pressure depressed, avoid phenothiazines
Sedatives-Hypnotics i.e. Barbiturates Meprobamate Glutethimide	Pupils normal Blood pressure and respiration depressed Nystagmus on lateral gaze Tendon reflexes depressed Ataxia, slurred speech Coma, shock Confusion	Maintenance of airway Support of cardiovascular and respiratory functions Gastric lavage or activated charcoal

What You Get For Your AMA Dues

The following material (abstracted from the September 21, 1970 *AMA News*) gives Dr. Parrot's answers to the questions: What's ahead for the AMA, and what do we get for AMA dues? Dr. Parrot is Chairman of the AMA Board of Trustees.

The AMA House of Delegates has approved a statement calling for intensified leadership from the AMA in areas of public awareness. These recognize public concern about physician shortages, national health insurance, the environment, nutrition, and health care delivery. Physicians have a great deal of expertise in areas like this, and if medicine doesn't provide the leadership in finding solutions, we are likely to be left with the job of trying to salvage programs designed by people without real awareness of the medical problems involved. This is half of our role in the future. The other, equally important, is service to the profession. The two inter-relate in many areas.

For instance, consider medical education. Today, there are 103 medical schools; in 1960 there were 85. Consider, too, audio-visual production, which enables the AMA to provide continuing medical education material for medical societies, hospitals, and individual physicians, along with patient-instruction. We are interested, too, in national educational campaigns on claims prevention and patient safety. The Board outlined quite a list of them in its report to the House last June.

The list of tangible AMA services is a long one, including the AMA's publications, medicolegal information, scientific films, an outstanding scientific library service, drug information, practice management advice, a group disability insurance program, and a member's retirement plan. These are just a few, but their value—if you could measure it in dollars—would be a lot more than a member pays in dues.

The intangible benefits are worth even more. Most of AMA's work is devoted to helping the physician practice better medicine—that's a major goal of our publications and scientific programs. And we have many dedicated members who serve on councils and committees and devote a lot of their time to evaluating the changing world of medicine—both from scientific and socio-economic aspects. The AMA has a role in accreditation of hospitals and educational programs, and in medical ethics work. All these things are important to medicine—they have to be done, and if the profession doesn't do them, someone else will have to.

Current AMA expenditures show only 11 per cent listed as "services for members." However, that doesn't include educational and scientific activities, scientific publications, and public affairs activities, much of which are really membership service. If members had to support the entire cost of AMA's activities, dues would have to be $188 a year. But even for $188 a year, members couldn't purchase what they're getting—in fact, they probably couldn't purchase it at all. What they're getting is the vast experience and skills of a central organization. The individual physician, when he pays his dues, is becoming a part of a strong, unified voice on national issues affecting our patients and our profession. It is easy to make all kinds of comparisons—AMA dues as compared with union dues, specialty society dues, and American Bar Association dues—but these are not relevant. The AMA is a unique organization fulfilling a special function. It is the physicians' national organization, and the dues for next year—about $9 a month—are necessary to do the job that our members, through their elected delegates, have decided is necessary.

When a physician pays dues to the AMA, he is making a membership investment; this investment creates a unifying factor which in turn helps create a more concerned, participating membership. Financial participation isn't the only aspect. Good members not only pay dues, but they also get involved in the affairs of medicine. This type of concerned member holds the key to our success in the future.

The Scientific Exhibits — — 205th Annual Meeting

The following information is pertinent to the scientific exhibit display at the 205th Annual Meeting of this Society, May 15 to 18, 1971. Those interested in participating may use the application form on page 743. (Please complete both sides.) Remove the page from *The Journal* and mail directly to Arthur Bernstein, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Application for space in the Scientific Exhibit must be submitted no later than January 1, 1971, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors.

1. *Time:* The exhibits will open officially at 12 noon, Saturday, May 15, and close at 5 p.m., Monday, May 17. On the intervening day the hours are 9 a.m. to 5 p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 3 p.m., Friday, May 14, and all exhibits must be in place by 11 a.m., Saturday, May 15. Exhibits must remain intact until 5 p.m., Monday, May 17, and should be removed from the exhibit hall not later than 12 noon, Tuesday, May 18.

3. *Cost:* The Society provides free of charge such space exhibitor may require, including booth with shelf, printed sign *(if requested),* and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, *including electrical connections.*

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent.* The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorses nor assumes any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

THE MEDICAL SOCIETY OF NEW JERSEY

205th Annual Meeting

HADDON HALL ATLANTIC CITY, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 15-17, 1971

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use *typewriter*, or *print*, please)

1. TITLE (Generic names only): .....

.....

Full Name and Degree of Exhibitor(s) .....

.....

City ..... State .....

Institution (if desired) ..... City .....

Aided by commercial or pharmaceutical company .....

Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

.....

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3. Is the exhibit free-standing or self-contained? .....
4. SIGN required: ..... SIGN not required: .....
5. Will backwall and dividers be required? (see sketch on reverse side): .....
6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15', depth 6'.

   Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear blackwall .....
7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. .....
8. Has this exhibit been shown in whole or part at any other scientific meeting? .....

   If so, when? ..... and where? .....

The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: ....

Return applicotion to Arthur Bernstein, M.D., Choirmon, Scientific Exhibits, The Medical Society of New Jersey. P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

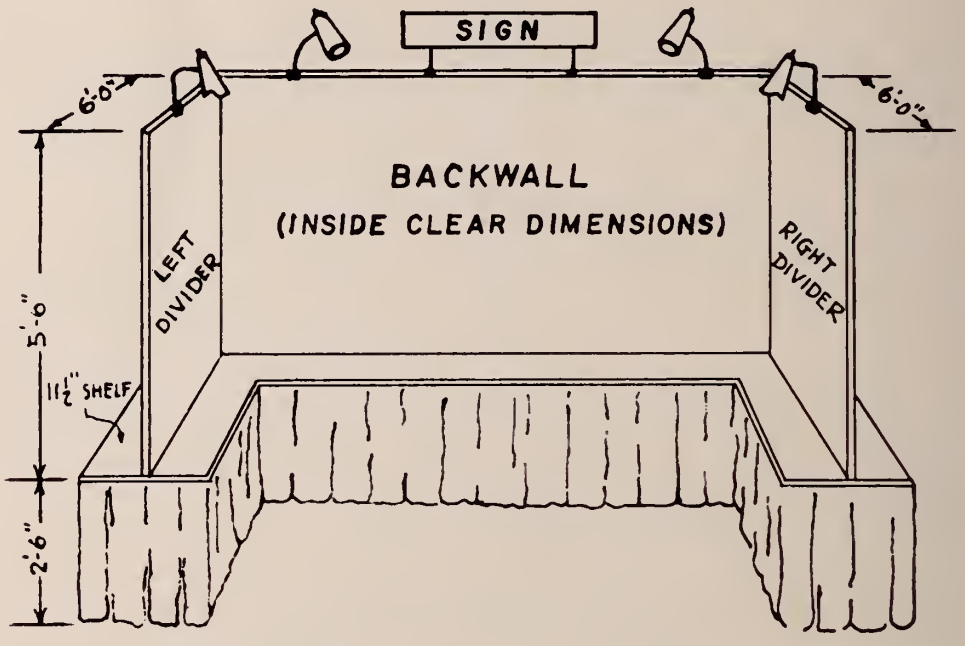
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
Shelving	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no
Overhead lights	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no

If your exhibit will not require backwall, or left or right dividers, please advise.

If a sign is incorporated within your exhibit, please advise, and one will *not* be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

ANNOUNCEMENTS

Caribbean Seminar

Albany Medical College announces the Twelfth Graduate Medical Seminar Cruise January 5 to 20, 1971. This is a fifteen day cruise aboard the "Gripsholm" of the Swedish American Line. Ports of call include San Juan, Dominica, St. Vincent, Trinidad, Barbados, Martinique, and St. Thomas.

Faculty members of the College will present a graduate program covering subjects in internal medicine, cardiology, oncology, psychiatry, surgery, and obstetrics and gynecology. Request has been made for continuation study credit by the American Academy of General Practice.

For further information, write to Girard J. Craft, M.D., Department of Postgraduate Medicine, Albany Medical College, Albany, New York 12208.

Drug Abuse Workshop

January 20, 1971 is the date and the Diagnostic Center at Menlo Park is the place for a seminar on community approach to the management of drug abuse. The program starts at 9 a.m. and will terminate at 3 p.m. AAGP has approved the program for six credits. Attendance is limited so early registration is advised. Send your check, payable to the New Jersey State Diagnostic Center, for $5 (which includes luncheon) to Milton R. Bronstein, M.D., 12 Carlton Road, Edison.

Topics to be covered include the role of methadone, the management of hallucinogen abuse, and clinical problems connected with drug abuse from the medical point of view.

Clinical Application Of Basic Sciences

The Burlington County Memorial Hospital has scheduled the following programs in its "Basic Sciences and Clinical Application" series for January:

January 7	Lymphoid-Immune System
January 14	Immunity, Genetics, and Virus Infections
January 21	Lupus Erythematosus and Rheumatoid Variants
January 28	Immunologic Abnormalities in Neurologic Diseases

The American Academy of General Practice gives one and a half credits for attendance at each session. All meetings convene at 3:30 p.m. in the T. J. Summey Building of the Hospital. For further information, please contact the Director of Medical Education, Burlington County Memorial Hospital, Mount Holly.

Eye Conference In Philadelphia

The Wills Eye Hospital announces the next of its now famous clinical conferences to be held on February 11, 12, and 13, 1971, at the Bellevue-Stratford Hotel in Philadelphia. Material to be covered will include a lecture on retinal detachment, symposia on cataract surgery and ocular surgery, and colloquia on muscle disorders, plastic surgery, and retinal diseases. For further information, please write to Robert D. Mulberger, M.D., Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia 19130.

Rehabilitation In Lung Diseases

New York University offers a full-time course on "Rehabilitation in Chronic Lung Diseases" March 1 and 2, 1971. This course will translate the theory and symbolic language of respiratory physiology into clear, clinical language of use to the practicing physician. It will emphasize the practical aspects of pulmonary function testing and the clinical rationale of physical therapeutic measures in rehabilitating patients ill with such lung diseases as chronic bronchitis and chronic pulmonary emphysema, and with neuromuscular and skeletal disorders of the thorax. Tuition is $100 and registration is limited. For an application please write to Dr. Edward H. Bergofsky, NYU Institute of Rehabilitation Medicine, 400 East 34th Street, New York 10016.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

December

2 and 9 — **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Uremia

2, 9, 16, 23, 30 — **Muhlenberg Hospital**
Plainfield
Gastroenterology

2, 9, 16, 23, 30 — **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

3 — **Somerset Hospital**
Somerville
Non-Surgical Therapy in Malignant Tumors

3 — **Burlington County Memorial Hospital**
Mount Holly
Intensive Radiation Therapy

3-4 — **Academy of Medicine of New Jersey**
Saint Barnabas Medical Center, Livingston
Culdoscopy Workshop

8 — **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Antibiotics

8 — **Bergen County Medical Society**

8 — **Cumberland County Medical Society**

8 — **TB-Respiratory Disease Association of Southern New Jersey**

8 — **Ocean County Medical Society**

8 — **Middlesex County Medical Society**

9 — **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Pulmonary Disease

10 — **Burlington County Memorial Hospital**
Mount Holly
Antimicrobial Agents

10 — **Somerset Hospital**
Somerset
Chemotherapy of Solid Tumors in Children

10 — **Sandoz Postgraduate Lectures**
Sandoz Auditorium, Hanover
Gonorrhea

12 — **Academy of Medicine of New Jersey**
Section on Plastic Surgery
St. Barnabas Medical Center
Livingston
Head and Neck Surgery

14 — **Academy of Medicine of New Jersey**
Paul Kimball Hospital
Lakewood
Cardiac Arrhythmias

15 — **Academy of Medicine of New Jersey**
Englewood Hospital
Englewood
Hepatitis

15 — **Academy of Medicine of New Jersey**
Burlington County Memorial Hospital
Mount Holly
Diagnosis and Treatment of Shock

15 — **United Hospitals Medical Center**
Newark Eye and Ear Infirmary
Glaucoma Surgery

16 — **Academy of Medicine of New Jersey**
Bergen Pines Hospital, Paramus
Coronary Cineangiography

16 — **Academy of Medicine of New Jersey**
Mount Sinai School of Medicine
New York
Hematology

16 — **Academy of Medicine of New Jersey**
Cornell Medical Center, New York
Transplantation

17 — **Morris County Medical Society**

17 — **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar

17 — **Somerset Hospital**
Somerville
Immunosuppressive Agents in Malignancy

1971

January

5 **Hudson County Medical Society**

6 **Camden County Medical Society**
Tavistock Country Club
Haddonfield

6, 13, 20, 27 **Columbus Hospital**
Hospital Annex
Simplified ECG for the family physician

6, 13, 20, 27 **Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Cardiology

6, 13, 20, 27 **Muhlenberg Hospital**
Plainfield
Gastroenterology

7 **Burlington County Memorial Hospital**
Mount Holly
Lymphoid-Immune System

10 **Bergen County Medical Society**

10 **Gloucester County Medical Society**

10 **Warren County Medical Society**

10 **TB-Respiratory Disease Association of Southern New Jersey**

10 **Ocean County Medical Society**

10 **Middlesex County Medical Society**

13 **Academy of Medicine of New Jersey**
State Hospital, Trenton
Drug Addiction

14 **Burlington County Memorial Hospital**
Mount Holly
Immunity, Genetics, and Virus Infections

19 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Leukemia and Lymphoma

20 **Academy of Medicine of New Jersey**
VA Hospital, Lyons
Emergency Room Care

21 **Burlington County Memorial Hospital**
Mount Holly
Immune Mechanisms in Lupus Erythematosus and Rheumatoid Variants

28 **Burlington County Memorial Hospital**
Mount Holly
Immunologic Abnormalities in Neurologic Diseases

February

2 **Hudson County Medical Society**

3 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Diagnosis and Treatment of Shock

3 **Muhlenberg Hospital**
Plainfield
Gastroenterology

3 and 10 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Cineangiography

3, 10, 17, 24 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

3, 10, 17, 24 **Muhlenberg Hospital**
Plainfield
Neurology

4 **Burlington County Memorial Hospital**
Mount Holly
Immunology and Neoplastic Diseases

4 **Saint Barnabas Medical Center, Livingston**
Hormonal Cytology

9 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Antibiotics

11 **Burlington County Memorial Hospital**
Mount Holly
Fibrinolysis and Fibrinolytic Agents

16 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Diagnosis and Treatment of Shock

18 **Burlington County Memorial Hospital**
Mount Holly
Emotional and Psycho-social Maturation

24 **Academy of Medicine of New Jersey**
Albert Einstein Medical Center, Newark
Pediatric Renal Disease

25 **Burlington County Memorial Hospital**
Mount Holly
Physiology of Puberty and Psycho-sexual Maturation

March

2 **Hudson County Medical Society**

2 **Academy of Medicine of New Jersey**
Section on Dentistry
Academy of Medicine Offices
Bloomfield
Saliva in Reference to Systemic Disease

3 **Camden County Medical Society**
Tavistock Country Club
Haddonfield

3, 10, **Muhlenberg Hospital**
17, 24 Plainfield
Neurology

3, 10, **Columbus Hospital**
17, 24, Hospital Annex, Newark
31 Simplified ECG for the family physician

4 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Drug Addiction

4 **Burlington County Memorial Hospital**
Mount Holly
Management of Infertile Couple

4 **Academy of Medicine of New Jersey**
National Institutes of Health
Bethesda, Maryland
Clinical Infectious Diseases

4 **Saint Barnabas Medical Center**
Livingston
Multiparous Trap

8 **Academy of Medicine of New Jersey**
Paul Kimball Hospital
Lakewood
Drug Addiction

9 **Bergen County Medical Center**

9 **TB-Respiratory Disease Association of Southern New Jersey**

9 **Middlesex County Medical Society**

10 **Academy of Medicine of New Jersey**
Overlook Hospital, Summit
Respiratory Failure

11 **Burlington County Memorial Hospital**
Mount Holly
Sexual Problems Seen in Office Practice

16 **Academy of Medicine of New Jersey**
Overlook Hospital, Summit
Renal Failure

16 **Academy of Medicine of New Jersey**
Burlington County Memorial Hospital
Mount Holly
Generation Gap in Medicine

17 **Academy of Medicine of New Jersey**
Atlantic City Hospital
Emergency Room Care

17 **Academy of Medicine of New Jersey**
Cornell School of Medicine, New York
Cardiac Drugs

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

18 **Burlington County Memorial Hospital**
Mount Holly
Biochemical Parameters of Aging

24 **Academy of Medicine of New Jersey**
Dental Section
Veterans Hospital, East Orange
Symposium on Intact Dentition

24 **Academy of Medicine of New Jersey**
Massachusetts General Hospital, Boston
Gastrointestinal Disease

25 **Burlington County Memorial Hospital**
Mount Holly
Hyperlipoproteinemias

29 **Cape May County Society**

31 **Academy of Medicine of New Jersey**
Cornell Medical Center, New York
Heart Surgery

31 **Academy of Medicine of New Jersey**
Symposium—Controversy in Medicine

April

1 **Burlington County Memorial Hospital**
Mount Holly
Pre-diabetic Syndrome

5 **Academy of Medicine of New Jersey**
Greenville Hospital, Jersey City
Emergency Room Care

6 **Hudson County Medical Society**

7 and 14 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Uremia

7, 14, 21, 28 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

8 **Burlington County Memorial Hospital**
Mount Holly
Recent Advances in Diabetes Mellitus

8 **Saint Barnabas Medical Center**
Livingston
Irradiation Therapy

13 **Cumberland County Medical Society**

13 **Bergen County Medical Society**

13 **Middlesex County Medical Society**

14 **TB-Respiratory Disease Association of Southern New Jersey**

14 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Difficult Diabetic Patient

15 **Gloucester County Medical Society**

15 **Morris County Medical Society**

15 **Burlington County Memorial Hospital**
Mount Holly
Management of Exogenous Obesity

20 **Warren County Medical Society**

20 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Leukemia and Lymphoma

21 **Academy of Medicine of New Jersey**
Yale—New Haven Medical Center
New Haven, Connecticut
Endocrinology

21 **Academy of Medicine of New Jersey**
Saint Michael's Medical Center, Newark
Cardiovascular Workshop

22 **Burlington County Memorial Hospital**
Mount Holly
Hypercalcemia

29 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar

May

4 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Diagnosis and Treatment of Shock

4 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Drug Addiction

5 **Camden County Medical Society**
Tavistock Country Club
Haddonfield

5, 12, 19 **Columbus Hospital**
Hospital Annex, Newark
Simplified ECG for the family physician

6 **Saint Barnabas Medical Center**
Livingston
Familia Toxemia

ATTENTION: INCORPORATED PHYSICIANS

MSNJ has been requested by the Division of Employment Security of the State Department of Labor and Industry to bring the following information to the attention of all physicians who have incorporated under the "Professional Services Incorporation Act."

Salary payments made to physicians and other employees of the corporations constitute wages subject to State unemployment and disability taxes. In addition the I.R.S. has ruled that payments to any and all corporation employees, including officers of the corporation are subject to Federal Insurance Contributions Act, Federal Unemployment Tax Act, and withholding taxes.

You are advised to bring the foregoing to the immediate attention of your accountant or business manager.


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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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The Doctor

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If, as Henry Brooks Adams speculated, "A teacher affects eternity; he can never tell where his influence stops", the outlook is optimistic.



LETTER TO THE JOURNAL

Too Many Cardiac Centers?

October 20, 1970

Dear Sir:

When the Chief Medical Examiner of our State questions the morbidity and mortality of open-heart surgery done here it behooves us again to review the problem and to investigate whether we should have fewer rather than more cardiac centers in New Jersey. Today ten hospitals are carrying out open-heart surgery and other institutions are planning to form open-heart surgical teams. The obvious result will be that no one single team will have enough cases to develop expertise. Mortality can then be anticipated to be higher than it should be. There should be one complete cardiac team (including open-heart surgery) for every one million of the population. Since, in the northern New Jersey area, there are only three and one-half million people, the number of centers for open-heart surgery at the present time is obviously more than is required.

During a recent visit to Ireland, a country of three million people, it had been learned that there had been seven open-heart teams until the Ministry of Health, alarmed by the high mortality, formed one open-heart center in Dublin with a resultant decrease in mortality. The Irish now plan to form two other centers. This will then conform with the suggestion of a population base of one million per cardiac surgery unit.

In 1965 the American Heart Association set up standards for cardiac diagnostic and surgical centers. They pointed out that the *daily* use of equipment and personnel in diagnostic, operating, and patient care areas is required. They said that these centers should be staffed and equipped to perform *all* necessary cardiovascular diagnostic procedures as well as closed and open-heart surgical procedures. They stated that each center should be approved for complete residency training suitable for Board certification in surgery. The report provides details on the necessary qualifications of physicians, nurses, social workers, and technicians and a description of the necessary facilities for complete patient care. No one single center in New Jersey is carrying out these procedures on a daily basis. The average center in our State now performs one open-heart procedure per week. Some of the units are doing even fewer.

An attempt at some form of regionalization was made by the Sub-Committee on Cardiovascular Surgery of the N.J. Regional Medical Program. This committee set up standards for such a center. The sub-committee is not empowered to do more than make suggestions. It apparently has not been effective in regionalization, since the number of centers continues to grow.

Because of the ever-increasing number of surgeons trained in open-heart surgery and the desire of Boards of Trustees to secure nebulous prestige for their hospital, with resultant publicity, the problem continues to mount.

The New Jersey Society of Thoracic Surgeons recommends that the number of centers be decreased, and that only two or three centers for cardiac surgery be utilized in the northern part of our State. This does not mean that any of the present teams would forego doing open-heart surgery, but only that all of the surgery be carried out in specified units. This would mean that the teams would have the advantage of *daily* procedures so that the members of the team who must carry out the extensive nursing care, the constant attendance of the resident staff, the technicians who perform gas analyses and so on, the medical cardiac resuscitation groups, and those in charge of pulmonary ventilation are constantly exercised in the performance of their duties.

In these few centers every patient being considered for open-heart surgery would be presented before a board including cardiologists,

surgeons, the private attending physician, physiologists, and so on. Here the decision to operate would be made. This should guarantee a certain amount of protection for the patient. All cardiac surgeons and all cardiologists involved in this type of work must receive privileges at these centers so that their patients can be admitted and they can continue to attend to these patients.

This plea is not unrealistic since, in the meeting of the State Society of Thoracic Surgeons, a number of surgeons have agreed to work in such a center. Cardiologists have also indicated a willingness (and in some cases an eagerness) to support such a plan. This plan may be opposed by some surgeons who insist upon going it alone, or by certain boards of trustees of hospitals who feel they should not give up a service which they consider prestigious. However, in the pursuit of excellence in patient care, our duty seems clear.

Joseph J. Timmes, M.D.
Professor of Surgery, NJCMD

OBITUARIES

Dr. Harmon H. Ashley

In 1957, Harmon H. Ashley, M.D., then 74 years old, was a laureate of this Society's Golden Merit Award. Dr. Ashley won his M.D. at the University of Buffalo in 1906 and was a pioneer in the development of otology and laryngology in our state. He was associated with the Princeton Hospital and active in the affairs of our Mercer County Medical Society. Dr. Ashley died on September 30, 1970 at the age of 87.

Dr. Emmet J. Connell

One of our State's early urologists, Emmet J. Connell, M.D., died on October 17, 1970 at the age of 81. Dr. Connell was in the famous Bellevue class of 1923, and did graduate work in genito-urinary surgery. He was attending urologist at St. Francis and Margaret Hague Hospitals, and at the Medical Center in Jersey City. A Fellow of the American College of Surgeons, he was a long-time member of the prestigious New Jersey Society of Surgeons. Dr. Connell was also active in the American Urological Association, and a member of our Hudson County component.

Dr. Thomas V. D'Amico

Thomas V. D'Amico, M.D., one of our state's best-known ophthalmic surgeons, died on July 4, 1970. Born in 1909, he was 61 years old at the time of his death. Dr. D'Amico was a member of the graduating class of 1937 at the University of Maryland Medical School. He was a Fellow of the American Academy of Ophthalmology and Otolaryngology and was associated with New York's Eye and Ear Infirmary. He had been senior ophthalmologist at St. Mary's Hospital in Passaic.

Dr. Benjamin Daversa

Word has just been received of the death on August 15, 1970 of Benjamin Daversa, M.D., who, prior to his retirement in 1965, was a resident of Spring Lake. Dr. Daversa was 66 at the time of his death. He was board certified in obstetrics and gynecology, a Fellow of the American College of Obstetrics and Gynecology, and a Fellow of the American College of Surgeons. During his period of active practice he was on the staff of the

Fitkin Hospital in Neptune, and was active in the Monmouth County Medical Society. Dr. Daversa received his M.D. at the Medical School of New York University in 1927.

Dr. Morris Dworin

One of our state's pioneers in radiology, Morris Dworin, M.D., died on September 29, 1970 at the age of 62. Dr. Dworin was a 1934 graduate of NYU Downstate Medical School (then Long Island College Hospital) and served for many years as chief of radiology and roentgen therapy at the Dover General Hospital. He was board certified in diagnostic and therapeutic radiology and was affiliated with both the American College of Radiology and the Radiological Society of North America. He was also active in the affairs of the New Jersey Radiological Society.

Dr. John B. Fabriele

At the untimely age of 62, John B. Fabriele, M.D., of Bayonne died on October 20, 1970. A member of the Hudson County Medical Society, he was an attending surgeon at the Bayonne Hospital and was one of the early members of the American Society of Abdominal Surgeons. He was a 1935 graduate of Hahnemann Medical College.

Dr. Howard H. Freedman

At the untimely age of 37, Howard H. Freedman, M.D., of Camden, died suddenly on October 23, 1970. Dr. Freedman was one of the youngest board-certified pathologists in the southern New Jersey area. He earned his M.D. at the Jefferson Medical College in 1959, at the age of 26. He was active in the affairs of the American Academy of Pathology, and was on the staff of the Cooper Hospital in Camden.

Dr. Gennaro Giannella

Gennaro Giannella, M.D., was born in Italy in 1927. He earned his doctorate at the Medical School of the University of Naples in 1953 and came to the USA in 1957. He went into anesthesiology and became attending anesthesiologist at both St. Francis Hospital and Christ Hospital in Jersey City. He was a Fellow of the American College of Anesthesiologists, and a member of the New Jersey State Society of Anesthesiologists. Dr. Giannella died on October 16, 1970 at the age of 43.

Dr. Leonard Harris

Leonard Harris, M.D., was a promising young orthopedic surgeon who died on October 3, 1970 at the age of 57. He was a Johns Hopkins alumnus, class of 1938. Dr. Harris was board certified in orthopedic surgery and was especially interested in pediatric orthopedics. He served in his specialty at both the Beth Israel and Crippled Children's Hospitals in Newark. Dr. Harris was active in committee work with our Essex County Medical Society.

Dr. Wilford J. Ratzan

A board diplomate in obstetrics and gynecology, Wilford J. Ratzan, M.D. was graduated at the New York Medical College in 1944. He served the Barnert Memorial Hospital in Paterson since the completion of his residency, and at the time of his death (at the age of 47) he was chairman of gynecology and obstetrics at that hospital. Dr. Ratzan was a Fellow of the American College of Surgeons and of the American College of Obstetrics and Gynecology.

Dr. Leonard Zweibel

A 1929 graduate of the old Long Island College Hospital, Leonard Zweibel, M.D. was an obstetrician and gynecologist in the North Jersey area, whose people he had been serving since 1931. He was identified with three hospitals in Newark—the Beth Israel, United Hospitals, and the Martland Medical Center. Born in 1905, Dr. Zweibel was board certified in obstetrics and in gynecology, and was a Fellow of the American College of Surgeons, as well as an active member of the New Jersey Obstetrical and Gynecology Society.

PUBLISHED TO REPLACE A PREVIOUS ADVERTISEMENT WHICH THE FOOD AND DRUG ADMINISTRATION CONSIDERED MISLEADING

The Food and Drug Administration has requested that we bring to your attention a recent promotional campaign for Garamycin Injectable (gentamicin sulfate) which featured a nationwide *in-vitro* hospital survey involving a comparison of sensitivity patterns of Garamycin Injectable and seven other antibiotics.

The FDA considers the advertising misleading in several respects such as:

The *in-vitro* chart contained in the ads, which compared Garamycin Injectable with seven other antibiotics, implied that Garamycin Injectable is clinically more effective than the seven other compared antibiotics. THE FACTS ARE (1) THAT DIRECT EXTRAPOLATION OF NONCLINICAL FINDINGS TO CLINICAL EFFECTIVENESS IS UNWARRANTED, AND (2) THAT THE ADVERTISED *IN-VITRO* COMPARISONS DO NOT CONSTITUTE A VALID BASIS FOR SUGGESTING THAT GARAMYCIN INJECTABLE HAS GREATER CLINICAL EFFECTIVENESS THAN THE COMPARED ANTIBIOTICS.

The *in-vitro* chart and information contained under the ad heading, "Indications" presented *in-vitro* data results in such a way as to imply that the drug is indicated for Gram-positive bacteria, such as *Staphylococcus aureus.* GARAMYCIN INJECTABLE IS NOT APPROVED FOR INFECTIONS DUE TO ANY GRAM-POSITIVE ORGANISMS.

We emphasize that Garamycin Injectable is approved for use only in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole- negative Proteus, Escherichia coli, and Klebsiella-Aerobacter.

Injectable Garamycin®

brand of gentamicin sulfate injection

Schering

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

BRIEF SUMMARY

INDICATIONS GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly Pseudomonas aeruginosa, Proteus and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

CONTRAINDICATIONS GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

WARNINGS **Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.**

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

PRECAUTIONS In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentration of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

ADVERSE REACTIONS The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

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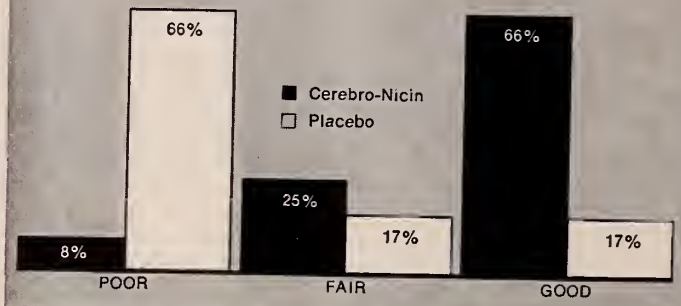
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient. R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
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Contraindications—Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69. 1966. 2. Dubin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Fitch, A. S. Methyltestosterone thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:930, 1959. 5. Farris, E. J., and Collan, S. W. Effects of L-thyroxine and isothyroxine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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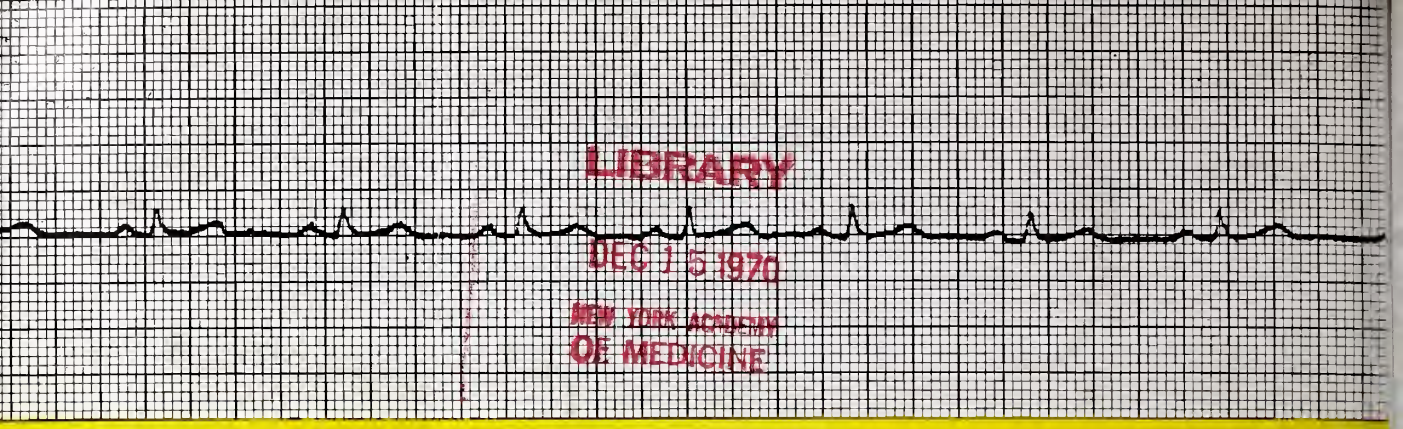
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